

A large, faint, circular ripple pattern is centered in the upper half of the cover, set against a light beige background.

# Peer-to-Peer

**HIV & AIDS Peer Educators Trainers' Guide  
for IMPACT Implementing Agencies**



FAMILY HEALTH INTERNATIONAL/NIGERIA IMPACT PROJECT

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## Foreword

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The early HIV/AIDS messages in the Nigerian media represented HIV and AIDS with a skull and crossbones and gave the impression that people died instantly upon getting the infection. This scare tactic only succeeded in creating suspicion in the minds of many that such a message must not be true, and therefore HIV and AIDS did not exist.

Things have changed since then. HIV continues to spread as people continue to engage in risky sexual and social behaviours. Thus, Family Health International, Nigeria, Implementing AIDS Prevention and Care project (IMPACT) has emphasized empowering various at-risk and vulnerable groups with information that moves them from the stage in which they are unaware of HIV and AIDS to the stage where they try new safe behaviour options and sustain the safe behaviour. This will help members of these groups prevent the spread of HIV and live a healthy and positive life.

IMPACT is adopting behaviour change communication (BCC) as a core strategy. This involves an interactive process with commitment to develop tailored messages and approaches and promote positive behaviours. The strategy relies on a variety of mutually reinforcing communication channels to disseminate tailored messages. Informal communication provided through peer education is one of these channels. IMPACT provides comprehensive HIV/AIDS programs in four states in Nigeria: Anambra, Kano, Lagos and Taraba states. In each of these states, there are common strategies and messages branded under common themes. Peer education is therefore an integral part of the BCC strategy. The peer educators compliment messages provided through the print and broadcast media.

Peer education has been tested and found to be an effective channel in behaviour change communication, and is used with other types of communication in the IMPACT project.

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### Peer education:

- Involves peers in communicating HIV prevention information and strategies in ways that can lead to behavioural change;
- Respects the influence peers bring to bear on each other;
- Honours informal education;
- Recognizes that education on HIV, abstinence, condom use, health issues and substance abuse has a better chance of leading to behavioural change when its source is a peer; and
- Focuses on the affinity among peers, especially among vulnerable people who may treat external sources of information with suspicion but are conscious of the solidarity between members of their own group

In building the capacities of Nigerian non-governmental organizations (NGOs) and IMPACT implementing agencies to carry out effective peer education work, two types of training programmes have been essential: (1) training those who train peer educators, and (2) training peer educators themselves. The effectiveness of peer educators in reaching their target groups is directly correlated to the quality of training they receive. Hence, the quality of the trainers' education has remained a critical concern to FHI/Nigeria. Drawing extensively from various STI/HIV/AIDS youth projects and their peer educators' training guides, FHI/Nigeria, with support from its Nigerian consultants, developed a training of trainers (TOT) facilitators' guide, *Train For Impact: Make Ready*, and a reviewed, shorter version entitled *Peer-to-Peer* for training peer educators.

Users of this document should realize that they are called upon to train peer educators and that they themselves must model the behaviours they expect the peer educators to promote. They also must demonstrate the communication skills they expect the peer educators to acquire in the course of the workshop. They should adapt the exercises in this guide to their local context and needs. The implementing agencies, in reporting their training to FHI/Nigeria, should include comments on the changes they made while using the guide.

We hope that when the FHI/IMPACT project is evaluated the peer education training component is judged to have met the set performance standards and contributed to attaining the project goal and objectives.

**Dr. Olufemi Oke**  
**Country Director**  
**Family Health International, Nigeria**

## Acknowledgements

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Family Health International, Nigeria, thanks the youth projects listed for sharing their guides with the FHI/Nigeria Implementing AIDS Prevention and Care (IMPACT) project. We acknowledge that these guides supplied the framework for this revised edition of *Peer-to-Peer: HIV & AIDS Peer Educators' Trainers Guide for Implementing Agencies*.

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The FHI/Nigeria behaviour change communication (BCC) staff Sina Falana (Adviser), Ekong Emah (BCC Officer/Arlington), Olufemi Faweya (Associate Director – Technical), Fola Richie-Adewusi (Senior BCC Officer), Olufemi Adeniyi (Senior Programme Officer), Dolapo Ogundehin (BCC Officer), Dayo Adedoyin (Evaluation Officer) and other FHI staff also contributed to the adaptation and ensured that the process was responsive to the needs of the FHI/IMPACT implementing agencies and target audiences.

It is also important to recognize the cooperation received from members of the FHI/IMPACT implementing agencies who participated in workshops to test the manual in Taraba, Kano, Anambra and Lagos states in Nigeria.

# Introduction

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## Preamble

This *Peer-to-Peer* guide is an adaptation and a Nigerian version of various training guides for peer educators developed to equip volunteers with skills for sexually transmitted infection (STI) and HIV/AIDS prevention project. The *Peer-to-Peer* guide is intended for trainers who will train peer educators. The trained peer educators will, in turn, be expected to take up the challenge to educate their peers on HIV prevention. The trainers will facilitate a process for peer educators to engage in self-examination, learn the basics of STIs, HIV and AIDS, improve their communication skills, and plan for peer education. The trainers will be leading peer educators to think and talk – about values, attitudes, beliefs, risks, behaviours, sex, sexuality and relationships. Peer educators will learn about their minds and bodies and what they need to do to keep both in a state of readiness – and how they can encourage their peers to do the same. By helping their peers to do the same, peer educators are expected to use the peer education approach to contribute significantly towards lowering the rates of HIV and STIs in their immediate communities and ultimately in the nation.

By the end of 2001, the Federal Ministry of Health put HIV prevalence in Nigeria at 5.8 percent. This means that approximately 3.1 million Nigerians are living with HIV. Taraba State, with the highest prevalence in the Northeast geographic zone (6.2 percent), is confronted with a growing epidemic. Observers, however, believe that national and state statistics may be underestimated due to several factors:

1. Every day, with unprotected penetrative sex and transfusion of infected blood, the number of infected people is increasing. This makes yesterday's figures outdated.
2. At the moment, only those public institutions that do testing are obliged to report numbers. Private laboratories may or may not. Many Nigerians use testing facilities that are privately owned instead of the public health facilities, clinics or the general hospitals and other designated test sites. Many avoid all testing facilities because they fear the psychological burden and stigma that a positive test result may impose on them. These people reason that they will save themselves worry and stress if they do not know whether they are HIV positive.
3. Only a few testing sites have so far been established in the country. Countless numbers of Nigerians, whether aware or unaware that they have been exposed to the virus, may never reach a testing site. Consequently,

most people who are infected do not know that they are infected. They also will not be included in the official statistics.

4. Many people who are unaware that they are infected are having unprotected sex with others, who, in turn, are having unprotected sex with other people. This spreads HIV like wildfire.
5. Like many people in the rest of the world, some Nigerians have limited numerical skills. A large part of the populations does not understand the practical meaning of numbers. Consequently, they do not see the statistics that are published from time to time as cause for alarm. One of the early exercises for peer educators will demonstrate how HIV can spread rapidly in a small, sexually active community when only one sexually active person is HIV positive. Nigeria is a country with a big population made up of many smaller populations.
6. Because of the stigma attached to HIV and AIDS, many people with the infection hide it. When HIV-positive people develop AIDS, they often die quietly in the bosoms of their families – or alone and abandoned. If anyone is paying attention or asks, the cause of their death may be represented as cancer or any one of the opportunistic infections that are actually responsible for the death. Many deaths as a result of HIV infection never find their way into the AIDS statistics. We have no way of knowing how many of the increasing numbers of suicides, killings, murder-suicides and disappearances in Nigeria are HIV related. But we do know that there is a correlation between high levels of violence against women, girls and boys – generalized violence and violence in which sexual organs are the targets, as in rape and incest – and HIV infection. And we know that violence, incest and rape are widespread in Nigeria, although we like to hide such incidences.

These are the main reasons why the numbers, percentages and cases we hear about, officially and unofficially, are only a few drops of water in the Nigerian HIV/AIDS epidemic.

While we need to be conscious of the dead and dying, the main focus of the training sessions will not be HIV and AIDS, but HIV and life.

Finally, this is a guide, not a prescription. There are various exercises and all are sufficiently flexible to be adapted for whatever situation trainers may face. Trainers using these exercises may soon find it impossible to return to the old authoritarian ways of teaching. They will eventually find that they can take any new information and design and re-present it in the form of exercises that are interactive, participatory and transforming. We hope that those who use this guide will become, with time, “authorities” in democratic teaching methods. In the meantime, have professionally fruitful training sessions!

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“To teach is to learn twice.”

“To teach is a far more primitive  
urge than to learn.”

When I was young and free  
and my imagination had no limits,  
I dreamed of changing the world.  
As I grew older and wiser,  
I discovered the world would not change,  
so I shortened my sights somewhat  
and decided to change only my country.  
But it too seemed immovable.  
As I grew into my twilight years, in one last desperate attempt,  
I settled for changing only my family, those closest to me,  
but alas, they would have none of it.  
And now as I lie on my deathbed, I suddenly realize:  
If I had only changed my self first,  
then by example I would have changed my family.  
From their inspiration and encouragement,  
I would then have been able to better my country,  
and who knows,  
I may even have changed the world.

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[WORDS FROM THE TOMBSTONE OF AN ANGLICAN BISHOP, WESTMINSTER ABBEY]

## Peer Education

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Peer education involves peers communicating HIV prevention information and strategies in ways that can lead to behavioural change.

Peers are people who are alike in several respects: age, gender, interests, language, use of time, aspirations and so on. Peer education respects the influence peers bring to bear on each other. Peer education honours informal education. Peer education recognizes that education about HIV, abstinence, condom use, health issues, alcohol and drug avoidance has a better chance of leading to behavioural change when its source is a peer. Peer education that focuses on young people is conscious of the factors that stand in the way of effective communication between adults and youths – especially where personal and sensitive issues are concerned.

Education comes from the Latin word educere. It means “to lead out,” as from a river or a blood vessel. Many people wrongly believe that the job of educators is to put things into people’s heads. But education really begins when we engage others in conversation, leading or pulling out what is in their heads and in their experiences, so that they can consciously examine and reshape their thinking where necessary. It is only after this work has taken place that the necessary behavioural change can begin.

We know that the messenger is as important as the message. Peer educators are key messengers at the interpersonal communication level. Trainers of peer educators will facilitate workshops using the content (the message) and methods (delivery techniques) that will be most effective with their peers. Several of the training sessions have been designed to allow the educators to reflect critically on their own values, attitudes and behaviours so that they may make necessary changes in their own lives and better appreciate the change process that may be required of others.

Because we tend to think that only the young have things to learn, and because the young are most at risk of contracting HIV, it is easy to forget that all groups have their peers. Trainers of peer educators should see this training as an opportunity to review and renew traditional educational methods and techniques. In effect, partner agencies implementing projects with youth in secondary schools, those in youth corps, men, women and young people in the church, transport workers, out-of-school youth, female sex workers and people living with HIV and AIDS (PLHA) need to adapt this manual to train peer educators in the different target populations.

The exercises in this *Peer-to-Peer* guide were designed with both trainers and peer educators in mind. You will



The work that trainers will be doing is important,  
but even more important is  
the work that the peer educators will be doing.

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find the language and ideas in this guide slipping between the two groups – trainers and peer educators – because we have both in mind.

Among the peer educators, there will be several with the potential of becoming trainers. Think of this layperson's cost-benefit analysis. If 20 copies of this guide are placed in the hands of 20 peer educators who expressed sincere interest, five might actually become trainers and five to ten might undertake higher levels of peer education work. Would this not be an inexpensive way of expanding the response to HIV? Would this not be an inexpensive way of expanding teaching and training resources?

The work of peer educators covers:

- Upgrading peer educator skills and planning for peer education work;
- Educating peers on STIs and HIV in one-on-one and small-group sessions;
- Assisting peers to access condoms, life building skills and STI and voluntary counselling and testing (VCT) services;
- Participating in HIV outreach, awareness and other public events;
- Reporting on their peer education work;
- Participating in peer educators' review and exchange meetings.

The work of trainers of peer educators involves:

- Facilitating the training of peer educators;
- Facilitating the planning of and reporting on peer education work;
- Assisting peer educators with strategies for dealing with difficult situations;
- Helping peer educators develop confidence and communication skills;
- Respecting, honouring, valuing and supporting peer educators;
- Ensuring that the training compensates peer educators for their time and effort.

In the workshops, the main focus will be on HIV and life. When it is necessary, the trainer will speak about HIV and AIDS instead of HIV/AIDS. A peer educator at a Lifeline workshop pointed out that if young people are to understand that the two conditions are very different, it is not helpful to speak of HIV/AIDS.

The HIV and AIDS crises have presented us with an opportunity to consider the purpose of the life we have been given. The *Peer-to-Peer* initiative, in this context, leads us to direct attention to the health of the whole body – from its largest organ, the skin, to its smallest cell. The skin, we know, is the body's first defence against HIV infection, and key cells fight to the end to defend the body against infection and disease. This also leads us to emphasize the importance of community care to enhance individual, family and community health for the prevention of HIV infection and the mitigation of the impact of AIDS.

### **Expected results of peer educators' STI/HIV prevention work**

Peer educators must know early, especially in their training sessions, what results they should expect. This will help them in their planning, peer education work, record keeping and reporting. It will also be vital for monitoring and evaluating the quantity and quality of their work.

Whatever reporting format is finally agreed upon between peer educators and trainers or supervisors, trainers should ensure that peer educators begin with a clear sense of what results they should plan and look for in their work.

Interactive and participatory education offer the only means for any real possibility of accomplishing behavioral change.

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[THE FUTURE ROLE OF UNICEF EXTERNAL RELATIONS, 1990]

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## Participatory Training Methods

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Years of studying families, communities and countries suffering from high levels of HIV infection convinced observers that the growing crisis was also the result of major communication problems.

The training exercises in this guide are interactive and participatory. The workshops and training sessions will be participant-centered, rather than trainer-centered. The emphasis will be on the interaction among participants rather than between participants and trainers. The main work of the trainer will be to facilitate the learning process. The trainer will facilitate, that is, make it possible for each participant to think about the self in new ways, interact with others, learn new things, unlearn some old things, listen, respond, reflect and share thoughts and feelings on a range of sensitive matters.

In the participatory education approach, trainers recognize and respect the particular resources each member brings to the group. Everyone knows things, everyone teaches things and everyone learns things. Much of the learning takes place through thinking and talking about things. The only examinations are self-examinations.

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If I give you one egg and you give me one egg,  
we will each have one egg;  
but if I give you one idea and you give me one idea,  
we will both have two ideas.

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[AFRICAN PROVERB]

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There will be a wealth of ideas, skills, talents and experiences among the participants. The trainer will try to draw these out as often as he or she can. No one person, no one type of communication style, no one resource should dominate the workshop. This includes even the peer educator trainer! Quite often, a lot of valuable information has already been shared, even before the trainer intervenes.

Because participatory methods do not encourage dependency on the trainer, participants develop confidence and problem solving skills. Self-confidence, independence and

co-dependence are especially important for peer educators who will be on their own, primarily relying on their own resources and those of their peers.

In training peer educators, trainers must use the same educational methods they want their trainees to use. People learn to educate in the way they have been educated. Because the educational experience of all of the peer educators you will be training is “teacher talk and chalk,” trainers will have to demonstrate other, more effective means of communication.

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We must practice what we preach.

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For example, instead of “teaching” about communication skills, the guide provides many opportunities for trainers to facilitate the practice of effective communication skills. And much of the work is “pair” work, to help prepare your peer educators for the one-on-one peer work they will be doing.

People learn more, learn better, learn more easily and learn with more lasting results when they participate fully, actively and equally in the learning process. They also enjoy the learning process more.

This guide relies on participants’ experiences, thinking and observation, rather than on lectures and presentations. The trainer’s presentations will usually follow rather than lead and will add to what the participants have presented. In the case of a major leading presentation (a video, role play or picture code), after the viewing the trainer will guide participants through a process of examining, verifying and proposing answers and solutions.

The participatory method turns the usual teaching methods upside down. After participants have thought about and shared their thinking with the whole group, the trainer adds other information. When this is done consistently, the peer educator will learn by example the importance of listening attentively and letting their peers say what they know, what they think and what they feel – before jumping in with instructions or advice.

The main purpose of our work is to bring about change. If, despite all the work and the workshops, there is no change, we will have to agree with the educator Dewey that there was “no learning.” This is why your workshop will have a lot of participant talk. Talking is how we express our thinking.

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Learning is not just learning things,  
but learning the meaning of things.  
Learning is learning to think.  
Learning should lead to change.  
If there is no change, there is no learning.”

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[JOHN DEWEY]

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So that no one feels at a disadvantage, the exercises are designed to accommodate any level or combination of levels of formal education or English literacy skills. The literacy skills, in the order that we learn them, are listening, speaking, reading and writing.

Many of the indigenous languages spoken in Nigeria are not written. Many native English speakers, including those who have attended school, have reading and writing difficulties. Some trainers and peer educators will be working with or in indigenous populations. They should encourage participants to use their first language as often as possible. Call on others to translate where helpful and necessary.

There are a variety of exercises in this guide. Those exercises that require writing should be done in small groups with at least one person who can make a note of points for reporting to the larger group. With a little imagination, even the writing exercises may be adapted for oral work

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Insight is crucial to change.  
But insight alone is not enough.  
It takes effort and will.

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[ALLEN WHEELIS]

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Change requires self-examination, self-reflection and self-understanding (insight), hard work (effort) and determination (will). The workshop exercises will involve investigation, thinking, talking one-on-one and in small groups, reporting back to the larger group, sharing thinking and feelings, and listening to the thinking and feelings of others.

The exercises outlined in this *Peer-to-Peer* guide will help participants move step-by-step from being unaware to aware, concerned and knowledgeable, willing to try the new behaviour and finally to sustained behaviour change.

What we think and how we think  
lead to what we believe.  
Our beliefs shape our values and attitudes.  
Our attitudes influence, and sometimes  
(but not always), determine our behavior.

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Although the guide is self-teaching, and notes have been provided for trainers, answers are not provided for every question/issue that may come up. We are confident that trainers and groups can put their heads together to arrive at solutions to peer educator problems. You will be helping your peer educators reach for meaning in their lives. This is your real training goal.

We recommend that, from time to time, trainers lead their groups in deep breathing exercises for internal organ and cell workouts, as well as other physical activities. These will stimulate mental activity and provide opportunities for thinking about the value of physical exercise for boosting the immune system.

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Culture is a way of being, a way of seeing, a way  
of feeling, a way of living.

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[MARTIN CARTER]

Death belongs to life as birth does.  
The walk is in the raising of the foot and  
in the laying of it down.

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[RABINDRANATH TAGORE]

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Culture is about how we undertake life's journey and the walk we take from birth to death. It is therefore also about sex, that act which brought us into being, and about death that ends life as we know it. Culture is about the way we live and when and how we die.

In training peer educators, you will need to encourage them to look at culture in this way. Too many see culture as song and dance! They will need to see that people in the North and at the foot of the Koma Hills have a different culture from people in the Ilaje Ese Odo in the Southwest or the Ijaw in the Niger Delta Area; that women in Ariaria Market in Aba or Onitsha Market have a different culture from the men in their communities and a different culture from women in a remote village in Ekiti State; that people who work directly on land or water live different lives from those who work in homes or in offices or in factories; that the culture of oil estate villages is different from the culture of communities based on rice work or mining; that coastal, riverine and hinterland communities each have their particular cultures; that people who speak dif-

ferent languages understand things differently, so we would not expect the indigenous people of northern Nigeria to be the same as those in southern Nigeria; and that boys and young men have a different culture from the girls and young women in their communities.

While remaining conscious of, and addressing, differences in culture and in peer education training, it must be remembered that all people, particularly the young, share things in common.

Death does not “belong” in the lives of any young person and untimely death is something we all dislike. Sex can lead to birth, infections and disease, and it can lead to death – our own deaths and, for some mothers with the virus, the deaths of many of the children they bring into the world. Death should come only with old age and after a life well and purposefully spent.

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If you are thinking one year ahead, plant rice.  
If you are thinking ten years ahead, plant trees.  
If you are thinking a hundred years ahead,  
educate the people.

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[CHINESE PROVERB]

Finally, this ancient Chinese proverb recommending people's education did not have in mind the HIV and AIDS crisis that is threatening Nigerian life today, but we should let it speak very strongly to us. The ABCDs of the *Peer-to-Peer* initiative goes a long way to encourage people to live a purposeful and well-spent life.

**Abstain,**  
**Be faithful,**  
**Condom use every time**  
**Drug and alcohol free**

But trainers should also encourage participants to take it one letter further, adding an “E” for “Education.” Urge participants to think a hundred years ahead and, through their peer education work, make their country better for their generation and the generations of Nigerians to come.

I have six honest serving men.  
 They taught me all I knew.  
 Their names are What and Where and When  
 And How and Why and Who.

[FROM THE "ELEPHANT MAN" BY RUDYARD KIPLING]

## Planning for the Training Workshop

Here is a simple way to plan for your training workshop and to share with peer educators how to plan their work: the five Ws and one H way. The five Ws are Why, Who, Where, When and What. The H stands for How.

The first question is why the training session or workshop is being organized. In other words, what are your objectives?

### Objectives

The word "objective" means aim, purpose or intention. Being clear about objectives is a key stage in planning your training. Objectives help the trainer and trainees to keep focused on what they are working to achieve.

- The overall objective of the *Peer-to-Peer* initiative is to improve HIV/AIDS awareness, knowledge and prevention strategies.
- Every set or module of the training exercises has a general objective.
- Every exercise has one or two specific objectives.

You will notice that in the objective statements, the term "each participant" has been used, although it is not really necessary since each exercise actively engages each participant. This is to help the trainer keep each peer educator's situation in mind while facilitating the learning process in the group. It is also to remind participants about the thinking and the particular work they have to do.

Most of the time, we recommend that objectives of a training session or exercise be shared with participants at the beginning. Do not assume your peer educators understand the meaning of the word "objective." You will need to explain this. Sometimes, we suggest asking participants to guess what a particular exercise was about, in the course of it or towards the end.

The objectives of any workshop or training session will depend on why the session is needed. What is the situation that calls for the training? What is the particular type of work your peer educators will be doing? What are some of the difficulties they have found? How much time is available for the training? What was the form and content of previous education? Who needs what, and according to whom? What led to the decision to organize the training?

### The work of the training and planning team

Who will be doing the training? How experienced is the person or team that will be doing the training? Although you may only need one facilitator per workshop, it is a good idea to have a small training team with more and less experienced trainers working together. In this way, you will be increasing your training resources.

Because the training methodology is participatory in nature and the guide gives step-by-step details and notes, trainers need not be highly skilled or knowledgeable. They are mainly required to facilitate the learning process. This means that many people can learn to become trainers "on the job."

Your team will need to discuss and answer these planning questions:

1. Who will be invited? (peer educator participants)
2. Where will the workshop be held? (venue)
3. When will the workshop take place? (timing)
4. How many days/hours will you have for the workshop? (duration)
5. What will peer educator participants do? (programme)
6. How will they do it? (process)
7. What will be needed? (materials)
8. What will the participants eat and drink? (refreshments)
9. Who will be responsible for restoring the venue to order? (clean up)
10. What will happen after the workshop? (follow up)
11. What information should peer educators bring back from their work? (reporting for monitoring, evaluation and documentation purposes)

### Participants

Plan with gender, age, religion, culture, town or village, literacy levels and previous training in mind

Who will be at the workshop? Will they be all girls, all boys, all men, all women or a group of both males and females? Will they be the same age? Will they be of the same religious and cultural background? Will they be urban street youth or semi-rural young people, or a mixture of the two? Will they be students or out-of-school

youths? What educational background and literacy levels will participants bring to the training?

What is their level of HIV and AIDS awareness? What is their peer education experience? Where and with whom will they be doing peer education work?

The idea is to plan so that you will know exactly, as much as possible, who will be in your workshop. Be mindful that each peer educator comes to the workshop with a unique personal, family, community, historical and cultural background. It may be useful to send out a pre-workshop questionnaire to participants to obtain this relevant information.

### **Plan for 20 people per workshop**

How many people will be at your workshop? Will there be 20, 15, 10 or some number in between? Experience has taught us that 20 is a good number. First, you will be sitting in a full circle or a half-circle, and a group larger than 20 will pose space problems. Even if you do have the space to accommodate more than 20 people, they may not be able to hear each other clearly because they will be sitting too far apart.

Another reason to stay with 20 and under is so that each peer educator can have several opportunities to talk during the workshop period. As a result of talking they will grow in confidence and improve their communication skills. The trainer and the group will have a better sense of each peer educator and his or her capacities.

A third reason for planning for 20 is that it gives you flexibility. If you do have to make room for one or two others, you can squeeze them in. If you plan for 25, you can end up having 28 or 30. If you plan for 15 you can end up with only 10. You can have a very good workshop with 10 people, so don't fail to proceed if, for some reason, you end up with a 10-person group. The main problem with 10 is that this number is too small for the number of peer educators you will need to be training on an ongoing basis. With HIV spreading as rapidly as it is, we cannot afford to train at the leisurely pace of 10 per session. Nor can we afford the superficial results that follow when we broadcast information to large, undifferentiated masses.

And of course, if you do not plan for a specific number, you will not know what to expect. You will not know if the space is large enough, if the seating accommodation will be adequate or if the amount of drink, food and utensils will be sufficient.

Many trainers are already accustomed to paying attention to these details in their planning, but some are not. Many of your peer educators may be doing planning for the first time; even if you are an experienced and careful planner,

you will need to share this step-by-step approach to planning with the peer educators and, of course, you will need to set the example.

### **The workshop venue**

When you begin to consider the question of venue – where the workshop will take place – you will again see why knowing the number of participants is important.

You will be looking for accommodations that can take up to 21 people (counting the trainer) seated comfortably in a circle or U-shape. Your workshop need not be inside a building. A good “bottom house” can work just as well. If the bottom house is on the small side, you should aim for about 12 to 15 participants. Of course, during the rainy season you will want to be indoors. You will also want to make sure that you choose a place that people will not have too much trouble getting to and from.

The workshop venue should be pleasant, clean, cool and airy. We cannot overstate this. Ugly, dirty and poorly ventilated training environments make learning difficult, if not impossible. It is also very disrespectful to participants who are being asked to do serious and important work.

Make sure that you visit the training venue beforehand so you know exactly what the accommodations are like. Get a firm commitment from the person or organization providing you with space. Check out facilities that religious, service or other communities might have. You may not need to pay and it is an opportunity to expand the response to HIV.

### **Plan to work in a circle**

We recommend working in a circle or U-shape because this arrangement allows for the most effective communication. We communicate with our whole bodies, but especially with the front of our bodies. All of your peer educators will be accustomed to sitting in rows of benches or chairs facing only the teacher and the backs of their peers.

We do not recommend using tables or desks, even when there is some writing to be done. Far better to have people experience the slight inconvenience of writing on their laps than to use desks as a crutch or a lower-body hiding place.

The physical arrangement of your workshop venue should let participants know immediately that their peer education sessions will be different from “school.”

For most of the session, you will be sitting in the circle on the same level (not at a head table) with the peer educators. When personal experiences are being shared, you will also share experiences from your life, not only because it is the decent thing to do, but also because you will be



teaching by example and peer educators will have an opportunity to learn whether you have learned.

When you work in a circle (again, we do not recommend desks), participants can better observe the body language of their peers. Working in a circle builds a sense of community in the group and creates bonds between participants.

Sitting and talking in a circle is far less intimidating than having to stand and address a group. Most classroom situations are designed to be unfriendly and to keep learners in their place and apart and in competition with each other.

The peer education workshop environment should be warm, friendly, comfortable, secure and close. Think of the group as one body, with trainer and peer educators as members of the body.

The U-shape is good for chalkboard work or when presentations need to be viewed. Close up the U-shape to form a complete circle when participants are sharing and at the end of the day just before people leave.

Urge participants to look out for each other, especially those across the circle in direct view, to see when someone nearby needs to touch, pat, squeeze or hug a group member who might be experiencing a difficult moment during an exercise.

### **Advantages of small-group work**

Most of the exercises have elements of small-group work. Very often, the peer educators will be working in pairs, sometimes in threes. Pair work has several advantages:

- Everyone can be working at the same time, on the same or different questions or issues.
- There will be no need to disrupt the circle, as participants need only turn to face the person sitting next to them.
- People who are shy about sharing their views with a large group find it easier to work with one other person.
- Sharing with one person builds confidence, improves the quality of the contribution and prepares the participant for sharing with the whole group.
- Peer educators can practice one-on-one work and develop their listening and reporting skills.
- Every group develops leaders. With six to ten small groups working, far more leadership development will be taking place because group members will be continually working on presentation and representation skills.

### **Pass the ribbon**

Before each workshop, the trainer will need to get a short length of red satin ribbon to pass from hand to hand when the exercise requires participants to take turns talking. If

you use the bowed HIV ribbon, uncross it and remember to remove the pin.

The “pass the ribbon” device ensures participation. The ribbon indicates that the person holding it enjoys the right to speak and will be listened to respectfully. When the person passes the ribbon, the next person knows that his or her turn has come. It cuts down on interruptions and it teaches patience. There is more participation when everyone knows that their chance to talk has been built in and will come. People are also more likely to listen attentively to hear each person’s take on a particular matter.

The ribbon also gives the person holding it the right to remain silent. If someone chooses not to speak and passes the ribbon on to the next person, allow the ribbon to go around the circle twice so that they can have a second chance. Many of our more memorable experiences and insightful comments have been shared during second rounds. We have also found that holding and stroking the ribbon is comforting.

Note: The ribbon is just a device. Trainers and their groups may want their own special object for passing. What you use should look good and feel good to the touch. A string of beads, bracelet, a book, a calabash, a smooth stone, a feather, a leaf – anything like this will work well, even an expired condom packet when appropriate! Stay away from pens and other penis-shaped objects that can be turned into microphones; you want people speaking from the heart and not broadcasting or performing as a deejay!

### **Time and timing**

When you are planning the timing of your workshops – the dates, days and hours –you will need to consult more than a calendar. First, you will need to have a sense of your peer educators’ training needs. Their first training session will require enough time to cover what knowledge they bring to the programme, the basics of STIs, HIV and AIDS, risk behaviours and their expectations.

Participants may not be able to put aside several days at a stretch. The planning team may therefore need to think of evenings or a combination of weekends and evenings. A six-day workshop may need to be spread over three weekends. Any time period will have advantages and disadvantages, but a long unbroken period can be transforming in a way that a few hours at a time can’t. Most likely, several workshops of different durations will be needed. The team will also need to think ahead to follow-up sessions for reporting and additional training.

Think about the holidays of the trainers, trainees, communities and organizations on which you will be relying. Saturdays and Sundays are free days for many, but they

may be holy days for others. Think about the season and the weather. Think about beginning and ending times. What are the other plans and commitments of your organization?

The times given for the exercises are estimates based on a 20-person workshop, but each one may take more or less time, depending on the group. After a while, trainers will have a sense of how many exercises can be attempted on one workshop day, and how they may be extended or contracted or varied in other ways without losing anything essential. On the whole matter of timing, planners will need to be realistic but thorough, as well as flexible and creative. The main thing is to bear in mind that time is a valuable resource.

We suggest that a timekeeper be appointed at the start of each workshop to alert the trainer and the group when the times for breaks are approaching.

### The programme and the process

You will want to be careful that the peer educators do not think, as many people now do, that a “programme” is a nice folded sheet of paper with events or activities printed on it. Be clear that a programme is what one does – planned activities, exercises or events that happen one after the other in a well-thought-out sequence.

The workshop programme and process will consist of the exercises you will be doing to meet the objectives of the training. You will need to keep a record of the exercises you use, so that you can vary them when you meet the group on other occasions. This is especially important when one trainer is working with several batches of peer educators.

### Materials

Most of the time your peer educators will be reaching their peers on a one-on-one basis. However, some might also work with groups in schools, religious organizations and in their communities. For this reason, we recommend that you work in a way that your peer educators can easily duplicate in their conditions. Most of the exercises in the *Peer-to-Peer* guide require no more than pen and paper; many call only for using their head.

The peer educator's tool kit may include the items listed below. But even without a kit, or with a partially equipped kit, there will still be much that peer educators can do, just with the training they have received. This is why the training needs to be as thorough as possible. Peer educators who will not be conducting workshops will need far fewer items.

A peer educator's tool kit can include the following:

1. Peer educator exercise book, *Ready Body* handouts and other support materials
2. Condoms for demonstration and distribution
3. A few sheets of flip chart paper (if available)
4. A few sticks of chalk and a blackboard eraser (in case flip chart paper is not available)
5. A few felt-tip markers
6. A roll of one-inch masking tape (for first-name name tags)
7. Writing pad (If peer educators organize workshops, they should ask peers to work with their own writing materials. This reinforces the notion that they are being invited for serious work.)
8. A simple reporting format
9. A bunch of HIV red ribbons and six-inch lengths of red ribbon to be passed from one participant to another
10. A few copies of the two-page culture, economic and psychology discussion guides

### What will participants eat and drink?

Since poor food and drink arrangements can leave a bad taste in the mouth of workshop participants, it is important to pay careful attention to refreshments. Additionally, it is always a good idea to let participants know exactly where resources came from for the mounting of a workshop, how they were found, and why.

One way of promoting voluntary work is to find opportunities for honouring, appreciating and being of service to voluntary workers. This is why catering arrangements should be careful. The training experience should leave participants feeling privileged.

However, you should make a note of telling peer educators who wish to organize a workshop that it should be about work and not about food. Even if they don't have the money or resources for food and drink, this is no reason not to have a workshop. They can ask participants to bring their lunch or ask those who can to bring sandwiches and other snacks and drinks to share with the whole group. You can also ask a religious or community or business organization to provide food and drink. Mobilizing resources from the community to cater for refreshments is another way of expanding the response to HIV and AIDS in Nigeria. We always need to be looking out for ways to allow others to contribute.

All of us, whether we are doing paid or unpaid work, must bear in mind that the HIV prevention work we are doing is essential to the survival of our communities and country.



### What to do at the opening of the workshop and every new day

On the first day of the workshop, trainers and organizers should arrive before the scheduled starting time to ensure that everything is in order.

The registration form is a very important document because it will be a record of participation and attendance. You should have one for each day so that you will have an accurate attendance record. It need not be formal. A sheet of paper with handwritten headings, passed around the group, works quite well. Leave generous space for writing. People often give inadequate information because forms force them to be too brief.

Make sure that the number of males and the number of females are noted, because it may be difficult to reconstruct this valuable bit of information later. The address, age and occupation of peer educators will supply important information on where most of the peer education work will be done. Important headings will be as follows:

Supplying name tags is useful, because it allows participants and trainers to address one another by name. A simple, low-cost method is to write the first name (or the preferred name) of each participant in large letters on a strip of one-inch wide masking tape.

As participants arrive, have them occupy seats next to each other. Suggest that they use the time to become acquainted, or better acquainted, with each other. If you wish, you may put up one of the talking points from the "Communicating Effectively" exercise set (Set 6, Exercise 1) for pairs to talk about with each other.

At some point during the first day, at a time when everyone is present, let participants know that the workshop will be starting on time and they should be punctual. Punctuality is really about discipline, especially self-discipline, and this is something everyone should practice in small and big ways.

For a workshop that is several days in duration, a reflection period on the past day and night is a good way to start the new workshop day to find out what has been happen-

### Two-Day Peer Educator Workshop on Abstinence

Saturday and Sunday, April 21 and 22, 2001 – 8.30 a.m. to 5.00 p.m.

<b>Day One</b>			
Number of males		_____	
Number of females		_____	
Name	Address	Age	Work/School
1.			
2.			
3.			

ing overnight (or during whatever period) in the minds and lives of participants. It is a quiet means of warming up to the work ahead and linking with past work.

### **At the end of the workshop day**

The early morning reflections can often serve as a useful form of evaluating the previous day's work. It has the added value of providing time for internalizing, processing and sometimes applying the recent learning.

However, you may wish to do brief oral evaluations at the end of the day, such as:

- Think of one word that says how you are feeling now.
- Rate how you feel about today on a 1 to 10 scale.
- How many marks out of 10 will you give to the work done to meet the objective of the last exercise? [Or each exercise done, or the workshop, or the session?]
- What was the most important thing you learned today?
- What did you especially like about today's work? What did you not like?
- What will you remember about today's work for a long, long time?
- What three things will you do differently as a result of this day's work (or workshop)?
- Who are the first two people you will talk to about today's work?
- In what ways have you benefited from today's work (or this workshop)?
- What one change will you make in your life as a result of today's work?
- Stand under the face that says how you are feeling now.



Oral evaluations are more participatory than written evaluations because they allow everyone, regardless of writing ability, to speak and to learn what other participants think. You may pass the ribbon or have a secret ballot for the rating or marking. If you do have a secret ballot, be sure to let members of the group tally the votes and share the results with the group – this is what really makes it participatory.

At the end of each workshop day, trainers may wish to lead peer educators in closing the session with a silent prayer. There are very few Nigerians who do not seek comfort in one or another faith. Time for a silent prayer allows participants to draw freely on available spiritual resources for support in meeting the challenges HIV presents them and their peers, without disrespecting anyone's faith.

You may also close with handshakes, hugs (self hugs and group hugs), fists to the heart, farewell bumps from the hip, or any other fun thing that the group enjoys.

How to conduct a silent body prayer:

- Have the group stand, make a complete circle, link hands, close eyes and prepare for the silent prayer.
- Tell the group to picture in their minds their various body parts. Recite a few: the big internal parts such as the heart, lungs, or liver; the smaller ones such as the cells, lymph nodes or blood vessels; substances such as blood and bone marrow; external parts such as skin, hands, feet and eyes; systems such as the respiratory [for breath], digestive [for food]; reproductive [for sex and babies] and, of course, the vital immune system.
- After a few seconds imagining and visualizing, give the group a minute or two to offer a silent word of thanks for any part or parts they wish.

### **Before peer educators set out for work**

During the workshop but just prior to the formal start of peer education work, make sure that peer educators are clear about expected results and reporting requirements. Trainers and peer educators will have to find a middle ground between reporting that provides valuable information for monitoring and evaluating the project and reporting that is burdensome. It is unfair to ask for what you do not plan to use. Ideas for a peer educator reporting form may be found in the peer education section.

Present the whole business of record keeping and reporting as a useful life and employment skill. Voluntary work is not only about giving service. It is also about gaining valuable experience, finding where their aptitudes and talents lie, deciding what one likes and does not like doing, learning new skills and disciplines, building capacities and enjoying one's chosen work.

Consider incorporating a simple commitment or recommitment ceremony to launch your peer educators with their new skills and new knowledge. Instead of casually handing out red ribbons at the time of registration, we suggest that the red HIV ribbon be ceremoniously pinned on each participant at the end. You might want to have peer educators do this in a peer participatory way, in which they receive each other's words of commitment, congratulations and good wishes.

**Reporting on the workshop**

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- Who was present? Attendance and participation: numbers by age, sex, occupation and community (town, village or local government area [LGA]). Add any other information (e.g. religion) you garnered during the workshop.
- Where it was held? (venue)
- When it was held? (dates and times)
- What were your objectives? What exercises did you use?
- How did it go? (Here you will report on your use of the “Bodywork Guide” and what worked, what didn’t and why, what you did differently and so on.)
- What significant things came out of the workshop?
- What decisions were made?
- What are the plans for meeting again?
- What reports were made?

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Development in human society is a many-sided process.  
At the level of the individual, it implies increased skill and capacity,  
greater freedom, creativity, self-discipline, responsibility  
and material well-being.

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[WALTER RODNEY]

The best hope for the future is not in huge government programs, in presidential promises, and complicated bureaucracies. ... But from the grassroots, where enthusiasm and commitment are strongest, that new solutions are likely to emerge.

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[[MIHALY CSIKSZENTMIHALYI, THE EVOLVING SELF]

## Suggested Workshop Agenda

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This section should be seen as a guide towards constructing workshop agendas, although the agenda for a five-day training is enclosed. The exercises that are selected for any workshop will be determined by a number of variables – along the lines of the points made in the previous section on planning.

Briefly, trainers and planners will need to be clear on the following, before determining precise agendas:

- The objectives of the training session being planned;
- The content and methods of previous training;
- The particular work and workplaces of peer educators in the group;
- The results expected;
- The time at the disposal of participants.

Some peer educators who have already been trained in HIV and AIDS may need refresher courses on STIs and HIV. Most, if not all, will need work on methodology and communication. From time to time, all will need self-awareness sessions.

The guide and agenda that follow are based on a 20-person group. The one-day and multi-day workshops assume the sessions will run from 8.30 a.m. to 5.00 p.m. with two 15-minute breaks and one hour for lunch.

Along with everyone's duty to observe punctual starting times, we should add here that trainers have a responsibility to end at the appointed time so that participants can depart as scheduled. Trainers may permit themselves some amount of flexibility with break and lunch times, but not with the final hour of the day. Since you will not want to end in an untimely manner, this means being very conscious about the time towards the end.

Training Preparation Checklist		
S/N	Activity	Comments
1	<b>Selection of participants</b>	
	Education	
	Sex (male / female)	
	School / workplace	
2	<b>Venue of training</b>	
	Seating arrangement	
	Lighting	
	Workspace	
	Ventilation	
3	<b>Training materials</b>	
	Flip chart / chalkboard	
	Markers / chalk	
	Notepads / writing materials	
	Pen / pencil / rulers	
	Files / folders	
	Overhead projector / flip chart stand	
	Transparency	
4	<b>Agenda for workshop</b>	
5	<b>Facilitators / trainers</b>	
	Invitation letters	
6	<b>Handouts</b>	
	Pre- and post- questionnaire	
	Evaluation forms	
	Activity sheets	
7	<b>Budget for training</b>	
8	<b>Accommodation for participants</b>	
9	<b>Tea breaks</b>	
10	<b>Lunch breaks</b>	
11	<b>Transportation</b> (if field trip is being considered)	

# FHI/IMPACT Project: “Care to Live Healthy?” HIV Peer Educators Training Workshop Agenda

DAY ONE	
Time/Duration	Sessions/Topics
<b>9:00– 11:00 AM</b>	<b>Opening Sessions</b>
20 minutes	Pre-Workshop Questionnaire
5 minutes	Welcome
45 minutes	Who Is Here?
15 minutes	Why Are We Here?
5 minutes	How Did We Get Here?
10 minutes	What Will the Training Be Like?
35 minutes	An Overview of Peer Education
<b>11:00– 11:15 AM</b>	<b>Tea Break</b>
11:15 AM – 12:15 PM	The Ready Body Test and Concept
12:15 PM – 1:30 PM	Life is Like a Ribbon
<b>1:30– 2:30 PM</b>	<b>Lunch</b>
2:30– 4:30 PM	How Well Do I Know Myself?
	Human Sexuality
4:30– 4:45 PM	Daily Reflection
	Three Ideas From Today That I Will Use in My Peer Education Work
DAY TWO	
Time/Duration	Sessions/Topics
9:00– 9:15 AM	Reflections on Day One
	Ready Body Drawing
9:15– 11:00 AM	What are STIs?
	What is HIV? What is AIDS?
<b>11:00– 11:15 AM</b>	<b>Tea Break</b>
11:15 AM – 1:30 PM	What is the Difference between HIV and AIDS?
	Why is the Difference Important?
	The Window Period
<b>1:30– 2:30 PM</b>	<b>Lunch</b>
2:30– 4:30 PM	When Should We Recommend VCT?
	What are the Connections Between TB, STIs and HIV?
	How Can Someone Get or Not Get HIV?
	How HIV Spreads.
4:30– 4:45 PM	Daily Reflection
	The Thing I Learned Today That Surprised Me.
DAY THREE	
Time/Duration	Sessions/Topics
	Value, Attitudes and Behaviours
	Personal and Community Values, Attitudes and Behaviour
	About Illness and Death
	Attitudes: Yes and No

DAY THREE (cont.)	
Time/Duration	Sessions/Topics
11:00– 11:15 AM	<b>Tea Break</b>
11:15 AM – 1:30 PM	Risks, Risky and Safe Behaviour Who is at Risk, Susceptible or Vulnerable? What Puts Peers at Risk of Exposure? Risk Assessment Techniques The Role of Alcohol and Drugs in HIV Transmission
1:30– 2:30 PM	<b>Lunch</b>
2:30– 4:30 PM	The Process of Behaviour Change Understanding Behaviour Change How to Motivate Others How to Support Behaviour Change Sexual Decision Making Peer Education and the “Care to Live Healthy” Campaign
4:30– 4:45 PM	End of Day Reflection One Change I Will Make in My Life As a Result of Today’s Sessions
DAY FOUR	
Time/Duration	Sessions/Topics
9:00– 11:00 AM	Overview of Effective Communication Overcoming Communication Barriers Approaching a Peer and Beginning a Conversation Presenting Clear Information and Receiving Feedback
11:00– 11:15 AM	<b>Tea Break</b>
11:15 AM – 1:30 PM	Active Listening Skills Arguments for Abstinence Assertiveness and Refusal Skills Talking To Groups
1:30– 2:30 PM	<b>Lunch</b>
2:30– 4:30 PM	Condom Negotiation Skills Condom Promotion and Distribution Using Print, Video and Picture Code Materials
4:30– 4:45 PM	End of Day Reflection My Most Memorable Moment Today
DAY FIVE	
Time/Duration	Sessions/Topics
9:00– 9:15 AM	End of Day Reflection My Most Memorable Moment Today
9:15– 11:00 AM	Care and Support for PLHAs Human Rights Issues Basic Home-Based Care Techniques
11:00– 11:15 AM	<b>Tea Break</b>
11:15 AM – 1:30 PM	I am a Peer Educator What Roles and Responsibilities for a Peer Educator What It Means To Be a Volunteer Peer Educator What Do I Need to Take To and Bring Back From My Work (Planning and Record Keeping Skills)
1:30– 2:30 PM	<b>Lunch</b>
2:30– 4:30 PM	Planning to Take Off Difficult Questions and Difficult Situations What If I Have To Refer My Peers? Developing an Action Plan Post-Workshop Questionnaire Final Workshop Evaluation
4:30– 4:45 PM	Workshop Closure

# Module One

It is good to be here,  
so let's start on the right note.





## Session I- Opening Session

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### 1.1. Arrival Registration and Handing Out Name Tags

### 1.2. Pre-Workshop Questionnaires

Hand out pre-workshop questionnaires as participants register. Facilitators should collect and collate the questionnaires as they are filled out. The questionnaires are then analysed to establish each participant's entry knowledge, attitude and skills on HIV and AIDS and experience with peer education and peer educators' training.

### 1.3. Welcome Address

The workshop coordinator or any other designated person welcomes everyone to the workshop.

### 1.4. Who Is Here?

The following exercise is conducted to help participants set the climate for the workshop.

#### Exercise: HIV and Stuff

##### Specific Objectives:

- Have participants greet fellow members of the group in a warm and friendly manner.
- Have participants introduce themselves and share personal feelings about HIV.

**Time:** 30 minutes

##### Materials:

A bag (or box) of stuff or assorted small objects – for example, a box of matches (or one matchstick), key, coin, ring, plastic flower, paper clip, photograph, dice, a brand name item, a piece of red ribbon, a battery, clothes pin, knife, bottle of pills, lipstick, etc.

##### Process:

1. Have your group stand in a circle with their hands free.
2. Tell them to greet the person on their right and the person on their left by saying “Hello, my name is . . . My organization is . . . I am from . . . ”
3. Demonstrate by using yourself as an example of how to greet the two people standing next to you in the circle. If you don't know them, say, “Hi, I'm so and so. How are you? What is your name?”
4. Tell the group that after greeting the people next to them they should find three other people in the group that they don't know, or hardly know, and get to know them better.
5. Re-gather your group, wait for them to quiet down, and introduce your session with a remark or two on the warm-up exercise.

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#### Trainer's Note

- I. This exercise is especially good for a group where people already know each other and need not go through the usual introductions.
- II. If participants are new to each other, make sure they actually introduce themselves.

6. Place the stuff in the middle of the group circle.
7. Ask each participant to take turns coming forward and selecting one item that makes him or her feel something about HIV. Tell the group that you want them to concentrate on “feelings,” not on what they have heard or think.
8. Tell each participant to say. “I am (state name) and this (name or show the item) makes me feel . . . about HIV.”
9. If you think that participants don’t “get it,” start the ball rolling by taking your turn first.
10. After everyone has had a turn, bring the exercise to a close by telling the group that this warm-up activity was intended to put them in touch with their feelings, with HIV and with each other. Tell them that it was also about learning to communicate their feelings to others.

### 1.5 Why Are We Here?

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#### **Specific Objectives:**

Participants should be able to:

- Discuss what they intend to achieve at the workshop and what might hinder this;
- State their expectations about the workshop;
- State how these expectations will be used as tools in HIV prevention; and
- State two of their fears about the workshop.

**Time: 15 minutes**

#### **Materials:**

- Felt pen
- Flip charts
- Markers

#### **Process:**

1. Introduce the session to participants.
2. Sit participants in semi circle.  
Go around the group asking each participant the question “Why are you here?” or “What are you expecting from this workshop? Note participants’ responses.
3. Skip whoever is not ready during the first round to give time for them to think it through.
4. Revisit those who did not respond at first.
5. Jot down responses.
6. Do the third round in the opposite direction from the first round and ask participants to state clearly what they think can hinder their ability to function positively during the training.
7. Jot down responses.
8. The trainer should clarify issues by addressing any fears, providing information on areas of concern and noting areas of concern that require follow up.
9. Review the workshop goal and objectives with participants.
10. Lead a discussion on what will indicate the attainment of these objectives by asking participants the question “How will we know that these objectives are being met?”

---

## Workshop Goal and Objectives

**Goal:** To develop and strengthen participants' knowledge, attitudes and skills in peer education

**Objectives:** By the end of the training participants will be able to:

- Describe the STI, HIV and AIDS situation and the implication for their community and Nigeria;
- Inform and educate their peers and others on STIs, HIV and AIDS prevention;
- Motivate and support their peers' behaviour change in the sexual and social activities that put them at risk of STI, HIV and AIDS;
- Support people affected by or living with HIV and AIDS (PABA and PLHA);
- Advocate the change of policies and attitudes towards STIs, HIV and AIDS.

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## How Will We Know That These Objectives Are Being Met?

We will know that our objectives are being met

- When more people in the peer group become aware of the causes and consequences of STIs and HIV infections;
- When myths and misconceptions about STIs and HIV/AIDS are no longer prevalent;
- When more people become informed and concerned about HIV and AIDS;
- When more people avoid risky sexual and social behaviours such as unprotected sex and multiple sexual partners.

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## 1.6 What Will the Training Be Like?

**Objectives:**

- To let each participant know how the workshop will be run
- To help participants and facilitators set rules to guide the conduct of the training, especially those rules that will establish a safe space for all participants

**Time:** 10 minutes

**Materials:**

- Flip chart
- Markers

**Process:**

1. Ask participants if they have ever attended a training programme. For those who say "yes" ask one or two to describe their experiences.
2. Inform participants what to expect at the training and include the following:
  - a. Duration of training, starting and ending hours, etc;
  - b. The seating arrangements and reasons;
  - c. Tea breaks and lunch breaks;
  - d. The fact that very little writing is expected of participants;
  - e. The concept of participatory learning and teaching, including the differences between training and teaching;
  - f. That participants will be doing a lot of exercises and reporting back.
3. Ask participants to name those rules they know will enable the workshop proceed smoothly and create a safe space for everyone at the workshop.
4. Generate a list based on their responses. Ensure that the following issues are dealt with:
  - a. Confidentiality;
  - b. Listening with respect;
  - c. Using language with which participants are most comfortable;
  - d. Interrupting the process to confront oppression;
  - e. That feelings are okay, in other words, we agree to give people the space they need to laugh or cry and to express their feelings;
  - f. That we agree to try new ideas, feelings, etc.;
  - g. That it is okay to pass (The trainer could introduce the concept of passing the ribbon at this point.);
  - h. That each person has a right to self-identity.

**1.7 Overview of Peer Education**

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**Objectives:**

- Participants will discuss briefly the concept of peer education and describe an STI/HIV/AIDS peer educator.
- Participants will state the characteristics of peer educators.

**Time:** 15 minutes

**Materials:**

- Flip chart
- Markers
- Tape and flip chart stand

**Process:**

1. Ask participants who is a peer. Note their responses and clarify as follows:  
Peers are people who are alike in several respects: age, gender, interests, language, use of time, aspirations and so on.
2. Ask participants to define or explain “education.”
3. Ask participants to define peer education. Note their responses.
4. Clarify participants’ contributions by presenting the following definition:

Peer education seeks to involve peers in communicating HIV prevention information and strategies in ways that can lead to behaviour change.

Peer education is the use of trained people to assist others in their peer group to make decisions about STIs, HIV and AIDS through activities undertaken in one-on-one or small-group settings.

5. Ask participants to explain who is a peer educator in the light of contributions so far.
6. Note their responses and clarify as appropriate.

A peer educator is a person who has volunteered and or been selected and trained to assist others in a peer group to make decisions about behaviour change with respect to STIs, HIV and AIDS.

Many people wrongly believe that the job of educators is to put things into people’s heads. But education really begins when we engage others in conversation, leading or pulling out what is in their heads and in their experiences so that they can consciously examine and re-shape their thinking where necessary. It is only after this work that necessary behavioural change can begin.

7. Remind participants of their expectations and that the goal and purpose of the workshop is to make them become effective STIs and HIV peer educators.
8. Inform them that effective peer educators have high self-knowledge, awareness and knowledge of STIs, HIV and AIDS. They demonstrate, through their attitudes and behaviours, the behaviour models they will be motivating others to adopt.

## Session II- Ready Body Test

### Session Objective:

- Have each participant take the “Ready Body Test” and exchange ideas on its use.

**Time: 2 hours**

### Materials:

- “Ready Body” handout
- Pen and paper

### Process:

- Introduce the objective of this exercise.
- Tell participants to take a strip of paper and number 1 through 14 down the side.
- Tell them to write “yes” or “no” next to each number on the paper as you read out each of the following questions.
- Inform participants that this is an anonymous test.

### Ready Body Test:

- 1) Do you exercise regularly?
- 2) Have you ever had sex?
- 3) Do you visit the dentist regularly?
- 4) Have you had many sexual partners?
- 5) Do you eat fruit and vegetables daily?
- 6) If you are sexually active, are there times when you do not use a condom?\*
- 7) Do you get your eyes checked?
- 8) Have your partners had other sexual partners?
- 9) Do you visit a doctor when you are sick?
- 10) Do you drink alcohol more than twice a week?
- 11) Do you sleep eight hours a night?
- 12) Have you ever had “leak” or other sexually transmitted infections?
- 13) Do you feel good about yourself?
- 14) Do you treat yourself when you have leak and other sexually transmitted infections?

\*Note: Tell participants to leave a blank space at questions 6,8, 12 and 14 if they not sexually active.

1. Tell the group to go through each answer and put a star next to it if they answered “yes” to 1,3,5,7,9,11,13 and “no” to 2,4,6,8,10,12,14. Tell them that 13 or 14 stars mean they are working towards having and keeping a ready body. Tell them to congratulate themselves! They are ready to reach for the moon!
2. Tell the group that if they answered “no” to 1,3,5,7,9,11,13 and “yes” to 2,4,6,8,10,12,14 they may not have a ready body.
3. Ask participants to define a ready body, based on their experience of the test. Note their responses and share with them the following definition:

A ready body is a body that is able to keep away infections as a result of behaviours and attitudes the individual has adopted to prevent and seek timely care for infections.

4. Ask participants to take out their “Ready Body” handouts with the questions. Ask them to spend some time comparing the questions with their answer sheet.
5. Ask each participant to select one item where work is needed and publicly commit themselves in front of the group to make a change of behaviour.
6. Honour each commitment with a hug, a handshake or a round of applause.
7. Go around the circle, naming participants in succession: teeth, tongue, teeth; tongue, teeth; tongue . . . (or “big toe, little toe” or any other two body parts). Have teeth and tongue get together in pairs and come up with five differ-

ent ideas on how the “Ready Body” test may be used in different peer education situations.

8. After about 10 minutes, have each pair share their ideas with the rest of the group. Everyone should be making notes of ideas for use and for inclusion in their peer educator exercise books.
9. Inform participants that the ready body concept underlies the work of peer education, as the peer educators provide information to the peers about making their “body ready.”

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**Trainer's Note**

Stay away from naming people according to sexual and reproductive organs, because too much of this negative labeling already exists in our society – and is part of the problem. Share this observation with the group.

## Session III-

### **Life is Like a Ribbon: Are You Tying Yours in Knots or Bows?**

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#### Session Objective:

- Have each participant conduct a personal self-examination and share some of what came up.

Time: 1 hour

#### Materials:

- 20 copies of the questionnaire

#### Process:

1. Share the objective of the session. Have participants close their eyes, center on themselves and answer the following 20 questions in their minds. Read out the questions, pausing awhile after each.
2. After the reading the questions, tell participants to open their eyes. Pass the ribbon and have them take turns sharing their thoughts and feelings about the exercise and any particular item that touched them. Give each person a copy of the questions to take, if you can.

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#### **Trainer's Note**

Participants will get in touch with their thoughts and feelings during this exercise. Before any participant speaks, he or she must be holding a red ribbon signifying HIV and AIDS. They should also be encouraged to express how life can be compared to a ribbon.

Also note that many participants will find it easier to describe their thoughts and more difficult to express their feelings. Therefore, in facilitating this session use encouragers to get participants to discuss their feelings such as:

“Enhm, those are your thoughts, but how did you feel then or how are you feeling now?”

or

“Thank you for sharing such private thoughts. Can you tell us how you feel in telling or thinking those thoughts?”

3. Each question can also be used in a session by itself, with participants sharing their response or as a discussion starter for one-on-one peer education sessions.
4. Ask participants to think of the ways they can use the exercise in peer education work.

### **Silent Questionnaire**

1. Life is like a ribbon. Are you tying yours in knots or bows?
2. When was the last time you really enjoyed yourself?
3. What are your three greatest strengths?
4. How are you using them?
5. What are your three greatest weaknesses?
6. What are you doing about them?
7. Name three people close to you (in Nigeria) for whom you have the greatest love.
8. When was the last time you hugged one of these people?
9. What is the main purpose of your life?
10. Think of your best friend. If he or she became infected with HIV, how would it affect your friendship?
11. Think of your best friend again. If you became infected with HIV, how would it affect your friendship?
12. Who is the person most likely to look after you if you became infected with HIV?
13. How many marks out of ten would you give yourself for your physical health?
14. How many marks out of ten would you give yourself for your emotional health?
15. How many marks out of ten would you give yourself for your spiritual health?
16. How many marks out of ten would you give yourself for your mental health?
17. A long-term partner suddenly suggests using a condom. What do you think? How do you feel? What will you say? What will you do?
18. You suggest to a partner (think of someone by name, even if you are not presently in a sexual relationship) that you should start using a condom. What will that person think? What do you think that person will do? What will you be able to handle?
19. What three things can you do to make your life better?
20. Are you doing them? If not, why?



## Session IV- How Well Do I Know Myself?

### Session Objective:

- Have participants assess and increase their self-knowledge.

### Materials:

- Markers
- Pen and paper
- Flip chart or chalkboard and chalk

**Time:** 30 minutes

### Process:

1. Introduce the specific objective of this exercise.
2. Ask participants to give themselves a mark from zero to 10 for self-knowledge. Explain: “If you think you know everything about yourself, give yourself 10 out of 10. If you think you know nothing about yourself, give yourself 0 out of 10. Most people will find themselves somewhere in between knowing everything and knowing nothing.”
3. After participants have decided on their marks, pass around two or three markers and have them write their mark on the palm of their hand.
4. Write the numbers 1 through 10 in a vertical line down the side of the chalkboard or paper.
5. Go around the group and have each person “show and tell” their mark. As participants “show their hand” and call out their self-knowledge marks, place a tick next to one of the numbers you have put up. After every four strokes, cross the group to make five – as you would on a tally sheet.
6. Give yourself a modest score after recording the marks of the group.
7. Ask participants with scores above 8 to sit together in one part of the room and the rest to sit on the opposite side.
8. Ask the participants with higher scores the questions under the “Our Biology” section below. The answers will help to “humble up” those who think they know a lot about themselves, provide an opportunity for teaching and learning, and deepen the use of the ready body theme. You may want to exclude people with health or biology backgrounds from some questions. Inform those participants who think they have over-scored themselves in self-knowledge that they can review their scores and change their sitting positions
9. Introduce and use the Four-Petal Shapers drawing to extend the exercise, giving a brief overview of how chemistry, feelings and thoughts, our moving ability, our environment and our past and future shape our lives and especially our health status.
10. Ask participants to say why knowing or not knowing about the seven body shapers can protect us or expose us to HIV infection.

### Trainer's Note

#### Our Biology

Do a reality check with the participants who gave themselves eight or nine out of ten marks for self-knowledge. As the word gets around, you may have to change the questions or make up new questions. Ask, for example:

- What is the largest organ of your body? (Answer: the skin)
- What is the smallest part of your body? (Answer: the cell)
- About how many cells are in a drop of your blood? (Answer: about 5 million)
- About how many white blood cells are in an average healthy body? (Answer: about 1 trillion\*)
- Where are the white blood cells produced? (Answer: in the bone marrow)
- Which diseases are you immunized against? (Answer should include those immunized by naturally acquired immunity, that is, by having had the disease, and those by artificially acquired immunity, that is, through vaccination.)
- What is the cervix? (Answer: the mouth of the womb where it opens into the vagina)
- Who is most at risk for cervical cancer? (Answer: Girls and young women who start having sex at a young age and who have sex with boys or men who have had many partners)

- How can a sexually active girl or woman find out if she is at risk? (Answer: by having regular pap smears; cancer of the cervix can be cured if detected early)
- What do you know of your parents' health from the time of their birth?

\* Note: If you are asked how much a trillion is, and you don't know, say so. Use the opportunity to discourage your group from speculating and guessing about things they do not know for sure. Point out that there is a lot of speculation and idle talk going on about HIV and AIDS: how many people in Nigeria or this or that village are infected; or whether so and so murdered his girlfriend and committed suicide because he was infected, and so on. This type of talk should be discouraged among peer educators.

### **Our Chemistry**

- There is also something called "body chemistry." We need to know more about our hormones, what they are, when and how they work, and what they are doing in our bodies. Hormones also affect our thinking and feelings.

### **Our Self-Moving Ability**

**Everyone has self-moving ability. No one needs to be a slave to biology; every ready body (old or young) can take steps to exercise control over their body chemistry.**

- Every one of us, including the poor or a disabled person, can move from an unsafe to a safe place. We can move from risky situations to situations where risk is reduced or eliminated; or from places where mental, physical, emotional and spiritual development is being held back to places where growth in all these vital areas becomes possible. The young man who travels from his village to a tertiary institution in the city is using his self-moving ability to grow, improve himself and increase his opportunities for personal development.
- We can make mental shifts and physical shifts; sometimes the mental movement has to come before the physical movement, and sometimes it is the other way around. When we physically remove ourselves from negative environments, we can make the mental relocation that is necessary for real forward movement. The girl or woman who feels herself trapped in a relationship with a man with many partners, and does not take action, is not using her self-moving ability.
- Feet, hands, head, mouth and eyes are not the only moving parts of the body. Internal organs, cells and systems are also self-moving – even while we sleep! There is always a lot of movement going on in the ready body, and even more movement when the ready body is exposed to infection or taken over by disease. Cells rush to sites of infection, battles take place between the body's defence force and the invading army. (All of this feverish activity and fighting generates a lot of heat.) Dead matter is flushed out, new matter is manufactured and anti-bodies are produced and released. Information and instructions travel around faster than in the blink of an eye.

### **Our Feelings and Thoughts**

Apart from the influence of the hormones on our thinking and emotions, we need to know about these aspects of ourselves in themselves, if we can really give ourselves high marks for self-knowledge. This is why many of the following exercises require participants to examine their thinking and feeling.

- An important reason for separating thinking from feeling (something we ask from time to time) is that thinking can determine how we feel and feeling can determine how we think. People who are positive thinkers usually feel pretty good about themselves. People who think about what they have and how to use this to their advantage feel better about themselves than those who are always thinking about what they don't have!

### **Our Environment**

We need to know about our environment. The "environment" is not only outside of us, but also inside us. It plays a big part in making us who we are. This saying explains it quite well: "You can take a man out of the country, but you can't take the country out of a man."

- In addition to trees, flood, drought and pollution, our environment has politics (a lot of it), religion, race, poor health services, communities of wealth and rivers of poverty. Our environment also involves cultural, legal, gender- and age-related issues, and other issues.

- And, of course, an attitude toward sex and HIV in the family, community and country is also part of the environment in which we live.
- In the Seven-Shapers diagram, the environment borders are fluid and move in and out. The environment can move in on us, but we can push it back. The double-headed arrow indicates that the environment affects individuals and groups and communities; but remember that individuals and groups can also affect the environment.
- Our first environment is the womb. Whether the mother is depressed or happy, well or malnourished, in good or poor physical or psychological condition, surrounded by or deprived of love and care will leave a lifelong mark on the son or daughter. A good start in life does not necessarily lead to a good life, but it helps a lot. In the same way, a bad start does not necessarily mean a bad life. It is what we choose to do with what we have that determines the life we live.
- Here are examples where HIV is related to the environment: If you are living with a family member who is HIV positive, the whole environment in the home can change when that person's status becomes known. When organizations say their mission is to work with people "infected and affected" by HIV, they are signaling that they intend to influence the environment positively. This, essentially, is also the work of peer educators. By their interventions, they can change the HIV environment in homes, schools, communities and the country.
- Our environment does not encourage frank and open talk about sex, our sexual organs, sexually transmitted infections or different sexual practices – it drives these things underground, into holes and corners. (Note: rape and incest are not sex, but an abuse of power where the abuser singles out the most vulnerable part of the victim for violation and violence.) Our environment stigmatizes and "bad talks" many things having to do with sex. HIV prevention work should create an environment where discussions about sex and related matters can take place freely.

### Our Past

We need to know about our past and about our prenatal (before birth) and childhood years when things happened to us that we can't remember. Neuroscientists (scientists who study the brain) and psychiatrists say that the first three years are the most important for shaping us. We need also to know about our parents' pasts – our mother and father, including absent fathers and their parents. Each generation shapes the next.

- It is worth repeating here that the mother's nutrition, her use or abuse of drugs, viral infections and the general state of her body and mind during pregnancy affect the unborn child. Our family experiences as children and adolescents can move us in one or more directions. The effects of these experiences can reach into our teenage and later lives.
- Our community, country or ethnic group past can also shape our lives. We don't have to look far for examples of this at work.

### Our Future

Finally, a high mark for self-knowledge means that each of us needs to have a sense of our future. Here are a few quick illustrations:

- If you are 17 and are unaware, unconcerned or unmotivated about getting to age 37 or 70, you are more likely to take risks that can have you dead by 25.
- If you "know," as so many young people say, "that something's got to kill you," and therefore you don't take precautions, something will kill you long before your time.
- If, on the other hand, you know where you want to be in five years' time, have a plan for achieving your goals, and are working according to your plan, you are a more "self-knowing" person than someone who does not. So, a high score for self-knowledge also requires us to "know" how we see our future, both our individual and collective futures.
- The line drawing of the "future" part of the Seven Shapers model is deliberately not solid. No one's future is cast in stone or clearly set out. When we set goals and make plans, we are outlining and working towards our future.
- Imagine for a moment, the future of a football team on the ground with no rules, objectives, guidelines, boundaries and goal posts!

## Session V- Human Sexuality

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### Session Objectives:

- Participants will familiarize themselves with human sexuality, including anatomy and physiology.
- Participants become comfortable enough to refer to human sexual organs by their real names.
- Participants will get in touch with their own sexuality.

**Time: 1 hour and 30 minutes**

### Materials:

- Flip chart
- Markers
- Labelled and unlabelled diagrams of male and female reproductive system and cardboards to produce labels

### Process:

1. Ask participants to define or explain the words “sex” and “sexuality,” noting the differences between the terms.
2. Note their responses.
3. Clarify by presenting and explaining the following information:

**Sex** refers to whether a person is male or female. This is defined by our physical characteristics, e.g. the male’s penis and the female’s vagina and breasts.

**Sex** also refers to an act of sexual intercourse and is an expression of love and intimacy between mature men and women.

**Sexuality** is how an individual thinks, feels and acts about his/her own body and that of others. It is the totality of an individual as they are expressed.

**Sexuality** has components such as:

**Sensuality:** This is about how people see themselves and how they feel about their body. This includes a sense of attractiveness and how it is displayed through dressing, dancing, and other features.

**Intimacy** includes such things as friendship and sexual intercourse.

**Sexual identity** indicates maleness and femaleness.

**Sexual behaviour and reproductive health** is the process of reproduction and the care and maintenance of reproductive organs.

**Sexualization** is a negative behaviour, such as the use of sexual intercourse or attractiveness to manipulate others through rape, sexual harassment, seduction, etc.

4. Ask participants to identify the relationship between the Seven Body Shapers and human sexuality and how they relate to HIV and AIDS.
5. Note their responses and make the connections as appropriate.
6. Ask participants to draw the male and female reproductive systems as they know it to be. (You may ask the males to draw the female organs, or vice versa, depending on the cultural and religious atmosphere.)
7. Participants can then paste their drawings on a wall and walk around to view the other participants’ drawings.
8. Settle the group down.
9. Ask participants what they learned or observed from the drawings. Note their responses.
10. Present a labeled diagram of the female and male reproductive systems, clearly identify the organs and explain their functions (Do not use highly technical terms with some groups of participants as this can lead to confusion. See trainer’s note.)
11. Present unlabelled diagrams of the male and female systems (internal and external) one after the other.
12. Ask participants to volunteer to label the individual organs and parts and explain their functions.

13. Summarize session by informing participants that the expression of human sexuality, especially as it relates to sexual intercourse, is at the heart of the spread of HIV. Further state that the lack of self-knowledge about human biology and chemistry further compounds the problem.
14. Ask participants to identify the relevance of this session to peer education.
15. Conclusion: Trainer should review the session objectives with participants.

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### **Trainer's Note**

#### **The external (outside) organs of males and their functions:**

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**Penis:** The main male sexual organ. It becomes stiff or erect when a man is sexually aroused. A man does not need to have sex just because he has an erection. The erect penis is used for sexual intercourse. Sperm and urine pass through the penis, but not at the same time.

**Scrotum:** This is found behind the penis and contains the two testes. The scrotum protects the testes from damage.

#### **The internal (inside) organs of males and their functions:**

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**Cowper's gland:** This gland secretes a watery fluid that activates sperm, making the sperm capable of fertilizing the female egg(s).

**Seminal vesicles:** These secrete a fluid that forms part of the semen and activates the sperm, making the sperm capable of fertilizing the female egg(s).

**Testes:** These are two round organs inside the scrotum that produce and store sperm cells and the male sex hormone (testosterone).

**Urethra:** This is the tube that passes through the penis and carries either urine or sperm.

**Vas deferens:** This is the long tube through which sperm pass from each testis to the urethra.

**Anus:** This is the opening through which faeces pass.

#### **The external organs (vulva) of females and their functions:**

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**Clitoris:** This is the small, pointed organ that lies between the labia majora and labia minora and the most sexually sensitive part of a female. It is sometimes removed during circumcision.

**Hymen:** This thin membrane covers the vaginal opening. It is often used to define virginity, although it can be broken during other activities besides sexual intercourse. It may provide some protection from infection to the vagina before it is broken.

**Labia majora:** These are two folds of sensitive skin, one on either side of the pudendal cleft and immediately below the pubis or fatty pad. The labia majora cover and protect the labia minora, clitoris, urethra and vaginal opening.

**Labia minora:** These are the thin, soft inner lips. They are pinkish in colour and very sensitive, the labia minora further protect the urethra and vaginal opening.

**Urethra:** This is a small tube and opening below the clitoris for passing urine.

**The vaginal opening:** This is seen when a female is viewed externally and is between the clitoris and the anus.

**Anus:** This is the opening through which faeces pass.

### **The internal organs of females and their functions:**

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**Vagina:** This is the organ and passage through which menstrual blood exits the body. It accepts the penis during sexual intercourse and functions as the birth canal during childbirth.

**Cervix:** This is the mouth of the uterus through which sperm must pass to fertilize the egg(s). During childbirth, it opens through muscular contractions.

**Fallopian tubes:** This pair of tubes is found on either side of the uterus and connects the ovaries with the uterus. Sperm travel up the tubes toward the ovaries, and the eggs pass down the tube toward the uterus. Fertilization normally takes place here. The fertilized egg passes through the Fallopian tube to the uterus, where it implants and develops into an infant. When no fertilization occurs, the unfertilized egg passes through the fallopian tube into the uterus and is expelled with the uterine lining during menstruation.

**Ovaries:** These are two small, egg-shaped organs connected, via the Fallopian tubes, to the uterus. The ovaries store and protect the female eggs (ova) and produce the female hormones, oestrogen and progesterone.

**Uterus or womb:** This is the organ in which a fertilized egg implants and the development of an infant takes place. Its lining is shed during menstruation. It contracts during labour to push out the infant.

**Vagina:** This is a canal running from the vaginal opening to the cervix and uterus. The vagina accepts the penis during sexual intercourse. Menstrual blood flows through the vagina during menstruation and an infant moves through it during birth.

### **Menstruation**

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Menstruation is a monthly bleeding that takes place when the egg is not fertilized. Each month, the uterus prepares a lining of blood and tissue, in case the fertilization of the egg takes place. If no fertilization occurs, the lining is shed through the vagina along with the unfertilized egg.

During and shortly after menstruation, the cervix is opened and the vagina wall is soft and can easily be bruised. It should be noted that if there is sexual activity with an infected person during this period and the sex is “unprotected”, there is a much higher risk of transmission of HIV.

## Session VI- How Pregnancy Occurs

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### Session Objective:

- Have participants be able to explain how pregnancy occurs.

Time: 10 minutes

### Materials:

- Newsprint
- Markers
- Handouts: “Ovulation,” “Menstruation” and “Pregnancy”

### Process:

1. Display the diagram of the 4 steps showing how pregnancy occurs.
2. Ask one or two volunteer participants to explain how pregnancy occurs.
3. Commend their efforts and complete as in trainer’s note.

Distribute copies of “How Pregnancy Occurs” to participants.

### Trainer’s Note

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#### How Pregnancy Occurs:

#### Step I:

##### Ovulation

Each month, one ripe egg in one of the ovaries leaves the ovary. If the menstrual cycle is 28 days, the ripe egg will be released on or about the fourteenth day. . Ovulation has occurred and the lining of the womb normally gets ready to receive the ripe egg.

#### Step II:

##### Journey of the female ripe egg

Looking at the picture, you can see how the female ripe egg makes its journey. The ripe egg moves to the egg carrying tube (Fallopian tube) to be fertilized by the male egg (sperm).

#### Step III:

##### Menstruation

If, after one to three days, the man and the woman fail to have intercourse, the lining of the womb folds up with the egg and comes out with menstrual blood.

#### Step IV:

##### Sexual intercourse

If intercourse takes place around ovulation, (and the man, ejaculates at the peak of excitement – in other words, deposits millions of his sperm into the vagina) sperm swim up the vagina, through the cervix and uterus to the tubes.

#### Step V:

##### Pregnancy

- One of the sperm will try to reach the egg that has been waiting in the tube to join with it.
- If both the male sperm and the female egg join into one, fertilization has occurred.
- The fertilized egg now moves to the womb and implants itself into the wall of the womb. This is the beginning of pregnancy and will result in the birth of a baby in nine months time.

## Session VII- Gender Roles

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### Session Objectives:

- Enable participants to share and expand their understanding of the phrase “gender roles.”
- Allow participants to explore gender roles in society and how these roles shape their self-image.

**Time:** 1 hour

### Process:

1. Share the objectives of this exercise with the participants.
2. Ask the participants to think about the duties and roles society expects men and women to perform.
3. After 2 minutes of thinking time, organize the group into pairs. Have each person share with their partner a) his or her understanding of the phrase “gender role”; b) two duties or roles society expects of them as a male or a female.
4. Have one person from each pair report on their group exchange.
5. After the reporting session, explain the phrase “gender roles” as those roles that males or females play in the society or community. These are roles related to what the society or culture expects from you based on whether you are male or female. Society prescribes roles for male and female, which shape the image people have of themselves. These roles are not fixed; they are subject to changes and can evolve over time.

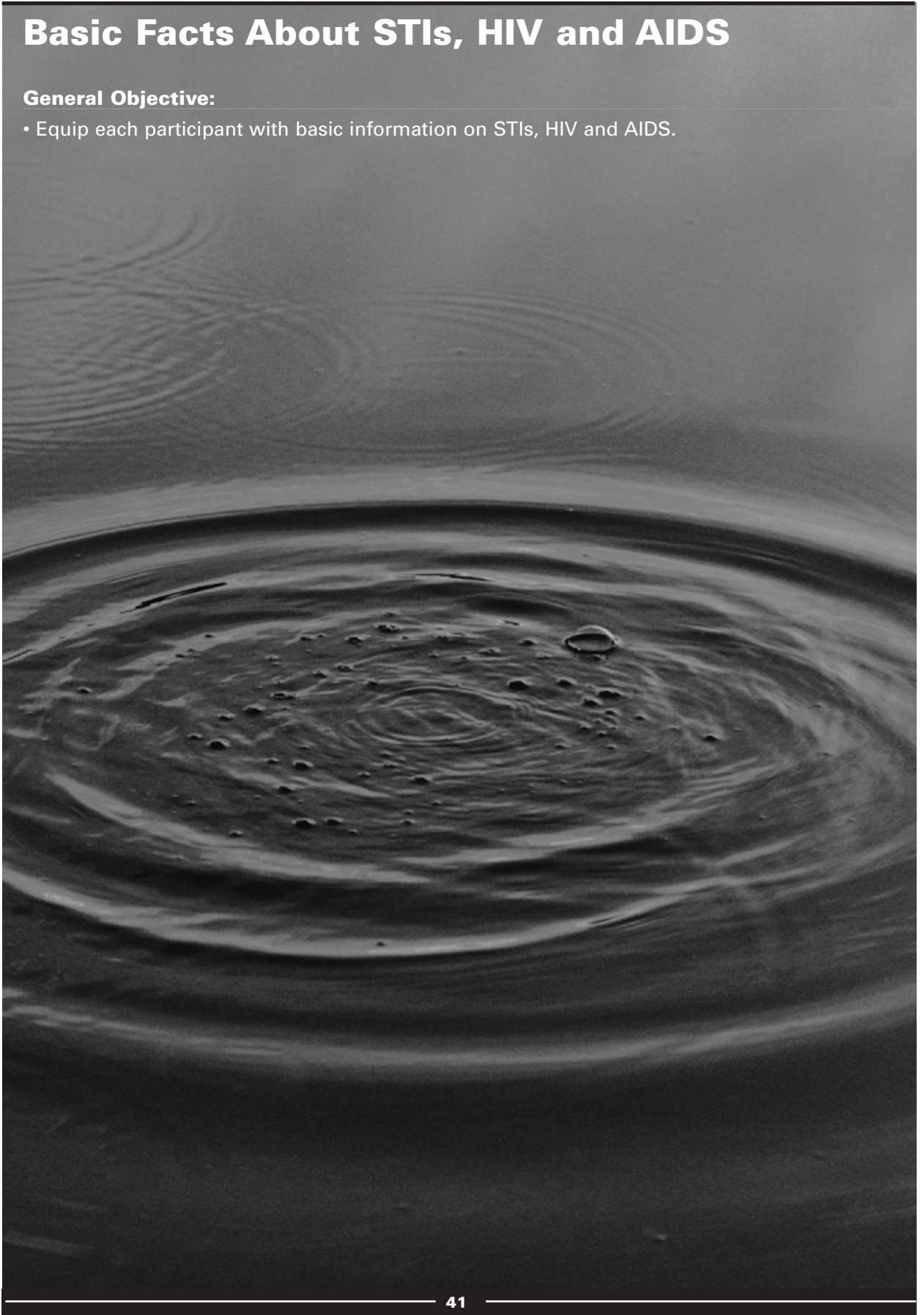


# Module Two

## Basic Facts About STIs, HIV and AIDS

### General Objective:

- Equip each participant with basic information on STIs, HIV and AIDS.



## Session I- Ready Body Drawing

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### Session Objective:

- Have each participant focus on and present one part of their ready body.

Time: 10 to 15 minutes

### Materials:

- Paper and pens or pencils
- Tape for mounting drawings

### Process:

1. Tell each participant to draw one part of his or her body that is ready. To those who protest that they “can’t draw,” tell them that any 3-year-old can draw.
2. Have them mount the drawings on the wall.
3. View the Ready Body gallery together, asking each “artist” to identify his or her work, the body part depicted, and describe what makes that part “ready,” and “ready” for what.
4. Have the group pay attention to how the space on the sheet of paper was used. Was the drawing expansive and taking over the whole sheet? Was it tiny and tucked away in a corner? Or was it centered in the space? What parts predominated? Did the participants draw more outer parts than inner parts? What can we learn about individuals and the group from what they drew, how they drew it and where they placed it? What can we learn from what participants said when talking about their drawings?
5. Tell them that their drawing skills are not the important issue at hand but what they expressed – while they drew and while they talked about the drawing.
6. Return to the group circle after the viewing and commentary.
7. Introduce the next session.

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### Trainer's Note

- This exercise is very useful for handling those participants who are late for the session, because they can start working on their drawings as soon as they arrive.
- Drawing is a leveling exercise. Except for the one or two gifted members of the group (this also makes it an opportunity for talent-spotting), most participants will have disabilities in this form of expression.

## Session II- What are STIs?

### Session Objectives:

- Have each participant recognize common STIs
- In a tabular form, participants should be able to state three named STI symptoms in males and females

**Time:** 1 hour

### Materials:

- Paper and pen
- Tape

### Process:

1. Share the general objective of this day's sessions and the specific objective.
2. Reveal a prepared chart with the following saying and lead participants in a discussion of its meanings.
3. Challenge participants to always keep this in mind, particularly in the next four to six sessions.
4. Ask someone to explain what words the letters STI stand for and the meaning of each word.
5. Explain that participants may have heard about STDs (sexually transmitted diseases) but the term STI (sexually transmitted infection) is now being used. When we hear the word "disease," we usually expect to see symptoms, but since many "STDs" are silent (that is, no symptoms may be seen or felt), we now refer to them as STIs.
6. Have each participant take one minute to draw an STI.
7. Have participants mount the drawings on the wall, placing similar ones near to each other. Or, have participants walk around the group and form small groups around similar drawings.
8. Have one person from each group attempt to depict similar STIs, to explain what the group was trying to convey. Individual artists may be called on to explain their work. Ask the group to comment on the categories: How were the drawings grouped? Male/female parts? Types of infections? Signs? Add information or correct as necessary.
9. Reassemble the group and organize participants into pairs. Ask half of the pairs to describe what different STIs look like. Ask the other half to describe what different STIs feel like.
10. Have one person from each pair share what they know with the rest of the group.
11. Tell the group that what they have been doing is looking at some STI "symptoms." Explain that a "symptom" is a "sign" or "indication." However, it is very important to know that many STIs, especially in women, have no symptoms. This means that people often don't know that something is wrong. Go through the symptom list.

### Main symptoms of sexually transmitted infections in males:

- Sores, ulcers, blisters, small hard lumps, rashes on and around the sex organs;
- Burning sensation while passing urine; frequent urination;
- Discharge (or "leak") from penis;
- Swelling in the scrotum (bag with balls or testicles) and in the groin area.

### Main symptoms of sexually transmitted infections in females:

- Discharge (or "leak") from vagina;
- Sores, ulcers, blisters, small hard lumps, rashes around and in the sexual organs;
- Pain, itching, burning, swelling in and around vaginal area;
- Lower belly pain;
- Frequent urination (There may be other causes for this.).

**Note:** Use the flip chart on STIs to enhance this discussion.

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Learning is not just learning things, But Learning the meaning of things.  
 Learning is learning to think. Learning should lead to change.  
 If there is no change, There is no learning.

[JOHN DEWEY]

## Session III- What is HIV? What is AIDS?

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### Session Objective:

- Have each participant learn the basic facts about HIV and AIDS.

Time: 30 minutes

### Process:

1. Divide the group in two smaller groups. Label half HIV; label the other half AIDS.
  2. Ask the HIV half to discuss the three words HIV stands for and what they mean.
  3. Ask the AIDS half to discuss the four words AIDS stands for and what they mean.
  4. Ask the two groups to appoint one person in each group to report. Make sure that different people get an opportunity to report. Your group is developing communication skills. Careful listening and accurate reporting are two important communication skills.
  5. Tell each group to listen carefully to the report of the other group. They will add only information not supplied by the first group and correct anything they think to be incorrect. You will also add and correct as necessary from the information below.
- HIV is the virus that causes AIDS.
  - Human means that it affects only humans and lives only in humans. The virus does not live in toilets, mosquitoes, cups or spoons, or on bed sheets or towels that people who have HIV might have used.
  - Immuno-deficiency refers to a lack of (deficiency) or breakdown of the human body's immune system. The immune system is the body's resistance or the "body's defence force" (BDF) for fighting off infections. The virus attacks and eventually overcomes the body's immune system, the BDF. The immune system is usually able to defend the body against many infections – except HIV.
  - A virus is a germ.
  - AIDS means Acquired Immune Deficiency Syndrome.
  - To acquire means to "get or develop over a period of time."
  - For definitions of "immune" and "deficiency" see above. The immune system does not break like an egg; it breaks down gradually over time. It gets deficient, or less and less efficient, under the relentless attack by the multiplying numbers of viruses in the body.
  - Syndrome refers to the group or collection of signs and symptoms (or indications) of diseases in a person who has AIDS, such as unusual weight loss (more than 10 percent of normal body weight), fever (stopping and starting or continuous), dry cough which hangs on, excessive tiredness, diarrhea for a long time (more than a month), swelling of the lymph nodes, respiratory tract infections including pneumonia, thrush, tuberculosis, night sweats, stroke.

## Session IV-

### The Differences Between HIV and AIDS and the Importance of Understanding the Differences

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#### Session Objectives:

- Help participants understand the differences between HIV and AIDS.
- Help each participant understand why knowing the differences between HIV and AIDS is important.

Time: 1 hour and 30 minutes

#### Materials:

#### Exercise 1: The differences between HIV and AIDS (45 minutes)

#### Process:

1. Share the objective of this exercise with the group.
2. Tell about six participants in the group before hand to move around or take up positions in the room as though they really had either HIV or AIDS.
3. After a few minutes of role-playing by those with HIV and AIDS, invite observations from the group on what they were seeing, thinking and feeling as they observed the role-playing.

**Note:** The HIV-positive people should be moving about as usual, but of course not having unprotected sex. The people with AIDS should be looking noticeably weak and may be lying down.

- Ask the observers: Did any of the HIV-positive people go to the assistance of those with AIDS, touch them or show them any sort of attention or affection?
  - Ask the role players: Did any of the HIV-positive people think that they would eventually develop AIDS and would need attention and affection?
  - Ask the those who played the roles of people with AIDS how they felt when they were asked to play the role, during the role-playing and afterwards.
  - Process the role-playing and then help players come out of their roles afterwards.
4. Form participants into three groups.
  5. Ask one group each to come up with three things that make HIV different from AIDS when they consider:
    - Group 1: Things that are happening **INSIDE** the bodies of people with HIV and AIDS
    - Group 2: Things that are happening **OUTSIDE** the bodies of people with HIV and AIDS
    - Group 3: The different **LIFESTYLES** of person with HIV and a person with AIDS
  6. Report as before with each group adding only new points.
  7. After the groups have reported, present the information below. The groups' three points on the differences between HIV and AIDS may have been organized in other ways. That is okay. The main point was to get every participant thinking about and discussing the differences.
  8. The points below can be linked to the ready body idea.

#### *Group 1: Various things are happening inside the bodies of people with HIV and AIDS.*

- HIV is the infection stage of the condition; AIDS is the disease phase.
- When the virus enters the body, it comes into contact with the front line of the body's defence system. In the early stages of infection (during the first few days or week) the infected person might feel as though the flu is coming on. HIV overpowers this front line (made up of white blood cells called macrophages) and makes its way into other body cells, living on them, destroying them and multiplying at a rapid rate.
- Antibodies (chemical substances) to the virus are produced. The body produces and releases antibodies into the bloodstream anywhere from six weeks to six months from the point of infection.. This six-week to six-month period (shorter or longer depending on the particular body) is called the "window period."

**Note:** The common lab tests look for the anti-bodies; they do not look for the virus itself.

- When the amount of viruses in the body reaches a high point and the amount of body cells that are supposed to fight off disease reaches a low point, the body is more open to other infections. HIV and various diseases then take over the body. This is when the person may be said to be living with AIDS.

*Group 2: The bodies of people with HIV and AIDS look different from each other on the outside. People with HIV look healthy while people with AIDS look unhealthy.*

- You can't tell when a person has HIV. A person who is HIV positive can look and feel as good as a person who does not have the virus. HIV-infected people can even look better, as many begin taking better care of their health and physical appearance.
- A person who is HIV positive can live for several years, looking just like a person who is not HIV positive. There are no signs on the person's body to show that he or she is carrying the virus.
- People who are HIV positive develop AIDS (or can be said to "live with" AIDS) when they have three or more signs of the syndrome (collection) of diseases listed earlier. Those with AIDS may have signs such as significant weight loss, thinning hair and skin diseases. Other signs that may not be as obvious to another person are the frequent bouts of diarrhea, enlarged lymph glands under the jaw, neck, armpits and groin. Thrush, a white furry coating on the tongue, the roof of the mouth and sometimes the vagina, is another sign. Note: No one of these signs by itself means that a person is living with AIDS.
- People who live with AIDS may not only look sick, but they may also feel sick. Diseases take over the body because HIV has broken down the body's defence force or resistance (the immune system). These diseases are caused by "opportunistic infections." They are called that because when the body's resistance is weak, infections of all types take the "opportunity" to invade and take over the body. Usually a normally healthy person can "resist" these infections. The body's immune system is designed to fight infections and disease.
- There are cures for most of these other infections and diseases, but science has not yet come up with a cure for HIV. A vaccine against HIV is now being tested.
- A person living with AIDS can return to feeling well when diseases are treated and symptoms disappear.
- People don't actually die of AIDS. Death usually comes after a series of illnesses and when the body finally succumbs to (that is, is overpowered by) one or more of the diseases which take over in the AIDS stage.

*Group 3: Those with HIV and those with AIDS lead very different lives. People with HIV can get on with their lives as usual, taking extra care with their health; those with AIDS may be too sick to carry on normally. They need care and medical treatment.*

- People who are HIV positive have to make important changes in their sex lives.
- People who are HIV positive have to be careful not to infect others or to get re-infected with the virus. Every time an HIV-positive person is re-infected, the body's resistance is weakened. AIDS will develop sooner because of this.
- Those who are HIV positive need to be extra careful not to pick up other infections. Every new infection, of whatever type, further weakens the immune system. We all know how easy it is to pick up a "bug" or virus when our resistance is low or down, and how hard it is to shake it off.
- Those living with AIDS need a lot of care and attention, medical and otherwise.
- Although both are infectious, a person who is only HIV positive is more likely to infect others than someone with AIDS, for two main reasons. First, the person with only HIV is more likely to continue to attract and desire sexual partners. Second, partners, caregivers and health care professionals are more likely to take risks with people who are HIV positive and don't have AIDS because they look good and their status may not be known.



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**Exercise 2: Why it is important to understand the differences between HIV and AIDS**


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**Specific Objective:**

- Enable each participant to understand why knowing the differences between HIV and AIDS is important.

**Time:** 45 minutes

**Materials:**

- Pen and paper

**Process:**

1. Organize your large group into four small groups. Ask each small group to think of at least five reasons why it is important to know the difference between HIV and AIDS. If your group has already been “trained” or you think they are pretty sharp, give them a target of at least 10 reasons.
2. If you wish, you may tell them to find endings for this sentence: “Knowing the difference between HIV and AIDS, can help . . .”
3. Tell the pairs to appoint someone to report their answers. Each group will have to listen very carefully so that their reporter will only share those points not already made by others.
4. Add points from below that did not come up.
5. Add to your guide any points that came from the group (giving them credit) that are not listed below.

**Knowing the difference between HIV and AIDS, can help people:**

1. Understand that it makes no sense to look at a person’s face or “ready body” and decide to have sex. The ready body may not really be ready.
2. Pay closer attention to their own lives and bodies and the lives and bodies of potential sex partners.
3. Actively think about HIV before sex, before exposing themselves to the blood of others, and before (long before) having children.
4. Become conscious of the fact that anyone can have the virus: men in “good” positions and “decent” girls and young women.
5. Understand the dangers of making love in the dark – in places where they can’t see, with people about whose sexual parts and pasts they have no information.
6. Realize that one act of unprotected sex with an infected person may be all that is required for transmission of the virus. Even individuals who are usually careful about sex can become infected.
7. Start taking steps to protect themselves from HIV and other sexually transmitted infections.
8. Infected with HIV to begin taking better care of themselves, physically and psychologically, including guarding against re-infection with the virus.
9. Including those who test positive, understand why they need to take personal responsibility for their health and their bodies.
10. Who have tested positive for the infection to have hope, because HIV does not mean death.
11. Who do not have HIV to take HIV seriously, because HIV does lead to dying before one’s time, and in what can be a very unpleasant manner.
12. Understand that it is less difficult to make changes in their lives and lifestyles now, instead of waiting until after being infected.
13. Who are infected with HIV to know that even if a test comes out negative (or non-reactive), they are infected and can infect others.
14. Who have good reason to suspect that they may be infected to know that a negative test result does not mean that they are not infected, simply because they continue to look good and feel good. In other words, “negative” may not mean “negative.”
15. Understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks of the lack of an infection months ago, not an infection (or infections) that may be only a few nights old or a couple of weeks old.
16. Understand that they are not in danger of “catching or getting AIDS” from a person living with AIDS. This can help remove some of the stigma surrounding people who are living with AIDS. However, there may be other infections and communicable diseases affecting the person living with AIDS that a caregiver needs to guard against, for example, tuberculosis and hepatitis B.

17. Know that those with AIDS can return to being well if they are successfully treated for AIDS-related infections and diseases.
18. Understand that caregivers and health care workers can actively set out to obtain and deliver treatment to PLHAs, instead of abandoning these patients. PLHA can be encouraged to seek and take treatment, instead of just giving up.
19. Understand that young people should realize that it makes sense to put off sex until marriage or a permanent relationship with a faithful partner whose history is known and clean, that is, infection-free.
20. Understand that young people should start taking their lives, and the lives of others, seriously.



## Session V- Window Period

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### Session Objective:

- Help each participant understand and be able to explain the significance of the window period.

**Time:** 1 hour

### Materials:

- Pen and paper
- Calendar

### Process:

1. Share the objective of this exercise.
2. Organize participants into pairs. Have one member of each pair, who thinks he or she understands the significance of the window period, explain it to their partner.
3. Ask those who think their partner did a good communication job to explain the answers to the following questions to the whole group: What is the window period, and why it is important to know about the window period?
4. Ask the rest of the group to listen carefully to see whether any important information has been left out of the explanations. They should also listen for any misinformation.
5. Correct any gross misinformation as soon as you hear it given, if no one else picks it up.
6. Have the group decide who was able to explain the window period best, and why that presentation was the best.
7. The following points are important. Share them to reinforce the learning about the window period.

### What is the window period?

- The window period is the time from HIV infection to when the usual lab tests can detect the antibodies to the virus in an HIV-infected person.
- The window period can last between six weeks to six months. Different bodies take different lengths of time to produce and release the antibodies, sometimes called “clues” to the virus.
- During the window period, the commonly used tests cannot detect the antibodies to the virus. Therefore, if someone is tested during that period, the test result will be negative even though they are infected. Some labs describe the findings as “non-reactive.”

### Why it is important to know about the window period?

- During the window period, a person can be carrying the virus and not know. That person can unknowingly infect another person through unprotected sexual contact.
- People who know about the window period will know why one has to be careful about giving and taking blood. Those who are careful about remaining HIV-free will know of the importance of donating blood at regular intervals so as to maintain a good supply at the blood bank.
- If a person has been exposed to the virus and takes the test soon after, the test results may show up negative. People who do not know about the window period may think that they have not been infected. They may spread the virus to other people.
- Those who know about the window period will understand that they must take a second test after about six months to know if they are infected with the HIV virus or not.
- These people will know that they must abstain from sex, or practice very safe sex, until they learn whether they were infected at that time that concerns them.
- People who understand the significance of the window period cannot be deceived by another who produces a lab report in order to get unprotected sex. They will understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks of an infection months ago, not an infection (or infections) that may be only a few nights old or a couple of weeks old.
- These people will know that if they have unprotected sex while waiting to have their second test, they are exposing themselves to HIV once again. And, of course, if they were really infected in the first case, they will be spreading the infection to other partners.

**How to explain the window period:**

1. Ask the person or group how HIV is transmitted. Explain and correct where necessary.
2. Explain what happens when HIV enters the body. (The frontline white blood cells try to resist the infection, but they fail. The system continues to try and resist. New forces come into the fight and antibodies to the virus are produced and released.)
3. Explain that it takes 6 weeks to 6 months for the body to produce and release antibodies to the virus into the blood system
4. Tell them, "Let's say you had unprotected sex with someone on January 1, and you are worried that you may have contracted the virus then. Don't go the next day or the next week for a test. That is too soon. The antibodies to the virus will not have been produced or released into the blood yet, and cannot be detected by the lab test."
5. Explain that the test looks for the anti-bodies to the virus. It doesn't look for the virus itself.
6. Use a calendar or draw or count off the first six weeks – to mid-February, for example. Explain that this would be a good time to go for a first test, but that the person must not have unprotected sex between January 1 and mid-February. Any additional exposure to infection by the virus would mean that the testing process and time line has to be started all over again. That person must then count the weeks and months from that new date.
7. But say that the test comes up negative. "Negative" does not mean the person is not HIV positive. It can simply mean that the infection is in the body, but the antibodies the test looks for have not yet been released.
8. This is why the person needs to go for a second test. Again, the person has to make sure that he or she does not have unprotected sex while waiting for the next test date.
9. Take the person through to the month of June. Explain that it has been known to take up to six months for antibodies to HIV to show up in some people's bodies.

**Note:** If the person to whom you are explaining the window period is concerned about exposure to the virus on a particular date, use that date as your starting point.

## Session VI-

### When to Recommend Voluntary Counselling and Testing (VCT)

#### Session Objective:

- Enable each participant to consider reasons for and against recommending voluntary counselling and testing (VCT).

Time: 1 hour 30 minutes

#### Materials:

- Pen and paper

#### Process:

1. Share the general objective of this module and the specific objective of this exercise.
2. Ask each participant to think about a situation of someone they know who:
  - a. May be worried about STI or HIV infection;
  - b. Is engaged in behaviour that puts him or her at risk of contracting STI or HIV;
  - c. “Knows” that he or she has an STI or the HIV virus, but has not taken a test;
  - d. Wants to get married, start a relationship, or have a child;
  - e. Is expecting a child (mother or father to-be) and may have been exposed to an STI or HIV; or
  - f. Is one of the above but lives somewhere in a locality in Nigeria where STI/VCT services don’t exist.
3. After participants have selected the situation they want to think about concretely, ask them to jot down points “for” and “against” recommending VCT.
4. After they have done this, ask them to decide on the following:
  - What action they will take?
  - How they will go about it?
  - What are the reasons for their decision?
5. If the group (or people in the group) are not comfortable writing, make it a thinking exercise and direct their attentions about what they should be considering. Remind them from time to time about the exercise’s goal, to keep them on track.
6. Organize the group into pairs for sharing with partners. Tell participants to share enough information that the partner can have a sense of the situation, without revealing the identity of the person. Remind the group of the importance of maintaining confidentiality, even while seeking help.
7. Tell participants to use the opportunity to consult with their partner on the best way of approaching the situation.
8. Ask participants to take turns presenting to the whole group on the following issues:
  - The situation
  - The arguments for and against recommending VCT
  - What they decided
  - How they will go about it
  - Why they made that decision
9. Ask the group to listen carefully to make suggestions and add information after each presentation.
10. Add any further insights or guidance as necessary.

#### Trainer’s Note

- This exercise may be used in a number of different ways. You can look at one category of people at a time. Each situation, from (a) to (f), can yield several different situations, especially if different age, gender, faith and race groups are considered separately. There will be other categories and situations that you and your group can propose.
- The exercise may also be used to monitor and evaluate how peer educators actually deal with such situations. Trainers may wish to take careful notes during exercises of this type. These can provide valuable anecdotal evidence of the work of peer educators that can be reprinted and reproduced as additional educational and awareness material.

The following are points to consider when advising someone about whether to go for the HIV antibody test.

1. Try to find out whether a person is just worrying or really needs to take a test:
  - Has person been having unprotected sex?
  - Has person had sex with someone who is HIV positive?
  - Has person had sex with someone who had an STI?
  - Has person had sex with a male partner who has had sex with a male partner?
  - Has person had sex with different partners?
  - Has person had a blood transfusion?
  - Has person shared a needle with a drug user?
  - Has person had sex with someone who would answer yes to any of the above?
2. Know about the locations of VCT and other testing facilities, as well as the quantity and quality of their services.
3. What if the testing facility does not provide pre- and post-test counselling?
4. What if the person doesn't take a test?
5. What if the test is positive?
6. What if the test is "negative"?

## Session VII-

### What Are the Connections Between TB, STIs and HIV?

#### Session Objective:

- Enable each participant to understand the connections between TB, STIs, HIV and AIDS.

Time: 1 hour

#### Materials:

- Pen and paper

#### Process:

1. Share the specific objective of this exercise.
2. Organize participants into three groups. Ask each group to come up with:
  - a. 10 reasons why knowing about STIs is important; and
  - b. The connections between STIs, TB and HIV.
3. Ask one person from each group to share their reasons. Each new presenter from the subsequent groups should only add new points to those already made. Explain that this is to test their listening skills. Make some of the points that are listed in the following sections.

#### Six Connections between TB and HIV:

1. Before the late 1980s, TB was considered to be at the brink of elimination. Then, new HIV-related TB cases and multi-drug-resistant tuberculosis (MOR-TB) began appearing.
2. Most TB patients in high HIV-prevalent countries are infected with HIV.
3. Today, HIV is known to be an important risk factor, contributing to the development of active TB from latent TB infection.
4. HIV also makes individuals with a recent TB infection more likely to progress rapidly to active TB disease.
5. Increasing TB cases put more pressure on medical resources, thereby reducing the availability of adequate medical facilities.
6. HIV-related stigma may prevent TB patients from seeking medical care.

#### Twenty Important Points about STIs and HIV:

1. HIV is a sexually transmitted infection.
2. HIV and many STIs are caused by germs during sexual acts.
3. Other STIs (for example, gonorrhea and chlamydia) are caused by bacteria.
4. Some STIs are more infectious at certain stages of the infection.
5. Many STIs can be cured.
6. There is no cure for the STI called HIV. Genital herpes is another STI for which there is no cure.
7. Using home remedies or self-treating with pills can be dangerous. STIs that can be cured but are not treated professionally do not go away. Untreated STIs can lead to serious health problems. Some, like syphilis, can lead to death.
8. Because different bacteria and germs cause different STIs, they need to be treated differently. When a doctor prescribes treatment after an examination, it is important to take the full treatment, even after the signs of the infection seem to have disappeared. Remember that not all STIs can be seen or felt. And some STIs show up sometimes but don't show up at other times. Someone can have an STI and not know it.
9. The overuse of antibiotics and other forms of misuse of antibiotics (black and reds and others) in treating STIs reduce their effectiveness in fighting infection and damage the body. Over time, the STI targeted can become immune to the antibiotic while the person's general health can be dangerously compromised. Antibiotics are serious medications, to be prescribed for specific purposes, and are not to be taken lightly.
10. Some STIs have no symptoms. That is, a person can have an STI and not know it.
11. Many girls and women with STIs have no symptoms.
12. Mothers can pass some STIs on to their newborn babies. Some STIs can affect babies' eyes.
13. The condom does not offer protection against several STIs.
14. STIs affect not only the sexual organs; they can also infect the area around the mouth and around the rectum (the behind or anus).

15. STIs can indicate that a person is careless about his or her general or sexual health.
16. A person who has an STI is at a much higher risk of contracting HIV through sex from an infected person. The sores, blisters, rashes, and soft spots in the skin from the STI can provide openings for HIV to enter the system.
17. STIs put additional stress on the body's resistance. Those who are HIV positive and get (and/or keep) an STI (or more than one STI) are likely to get sick more frequently, and develop AIDS more rapidly. When the body has to keep fighting infections, the body's resistance breaks down over time. When it can no longer resist, infections and diseases take over and the body dies.
18. People who are embarrassed or ashamed to examine their sexual organs or have them examined by health care professionals can unknowingly have STIs and pass them on to others.
19. Those who do not pay attention to the sexual organs of their partners risk infection by STIs. You can get a sexually transmitted infection from one partner; you don't have to have many partners to get an STI. Of course, with each partner, the risks increase.
20. STIs can make one's sex life, and life in general, very unpleasant.

## Session VIII-

### How Can Someone Get HIV? or Not Get HIV?

#### Session Objective:

- Enable each participant to understand how HIV is transmitted and is not transmitted.

Time: 1 hour

#### Process:

1. Share the title and objective of this exercise. Ask someone in the group to say why this exercise is not looking at AIDS.
2. This is an opportunity for the group to be reminded that HIV is an infection that travels or is transmitted. AIDS is not transmitted. AIDS is not passed on. AIDS can't be caught. AIDS is developed.
3. Ask the participants to form new small groups of two or three people each.
4. Ask half of the small groups to come up with three ways a person can get HIV.
5. Ask the other half of the small groups to come up with three ways a person can't get HIV.
6. Allow a few minutes for discussion. Report as before. Remind the groups to listen carefully to the reports because they will be expected to add points that the other groups did not mention.
7. After the first set of groups (the "How you can get HIV" groups) has reported, add points as necessary from the notes below. Do the same thing after the second set of group has reported.
8. Ask for a few volunteers to say how someone could get HIV from a person who has AIDS.
9. To those who say "sex," ask them to imagine that they have the virus in their bodies in very high quantities. They are suffering from constant diarrhea, coughing and excessive tiredness. These are only three of the symptoms a person living with HIV and AIDS (PLHA) might have. Putting aside emotional, psychological, economic and other problems they will be having, they are not feeling good. They are not looking good. Ask them: Would you be wanting sex? Would you be attracting sex partners?
10. What a PLHA usually wants and needs is care and affection! People who are not living with the virus need to practice showing care and affection in all their relationships, starting now – just in case they are ever put to the test.

#### People can get HIV in three main ways:

1. Unprotected sex (any kind – vaginal, oral or anal – where penetration is involved, including sex where there is no ejaculation or "come") with an infected person. Chances of infection increase significantly when STIs are involved.
2. Blood transfusion or any blood-to-blood contact, including sharing needles used to inject drugs.
3. Mother-to-child (in the case of an infected mother during pregnancy, during delivery or breastfeeding).

#### Further consideration about HIV infection:

- The virus can be found in three main body fluids – semen, vaginal secretions (wetness in the vagina) and blood – of the HIV infected person. Just one drop of any of these three fluids will have HIV in very high quantities. Small amounts may be in other body fluids. Urine and saliva that have blood will also have the virus.
- An infected person can become re-infected with every act of unsafe sex. This increases the viral load and can add different virus types to those already in the body.
- Where mother-to-child transmission is concerned, it is believed that when babies breastfeed and the nipples become sore, they may bleed and contaminate the HIV-positive mother's milk. Many babies (but not all) who are born to HIV-positive mothers may pick up the virus either in the womb, during the birth process (where blood and vaginal fluids are present), or after birth through breastfeeding.

**People can't get HIV, from:**

- Handshakes, touching, swimming or bathing with an infected person; sharing utensils (cup, plate, spoon) with an infected person; toilet seats; mosquitoes; using an infected person's towels and clothes, or sitting next to or sharing a bed with an infected person. (HIV cannot live outside the body. In order to survive, the virus needs the food supply of the cells in body fluids that have cells. This is why HIV will not be found in perspiration; sweat is mainly salts and water.);
- Hugging and kissing (if there are no bleeding gums and broken skin);
- Massaging;
- Masturbation, that is, self-massage (rubbing and stroking of self) or mutual-massage (rubbing and stroking by two partners) of the sexual organs. (Note: If one or both partners are infected, care must be taken to ensure that there are no openings on the skin where the virus can enter.);
- Sex where both partners are not infected and remain faithful to each other
- Not having sex with infected people or those whose HIV status is not known;  
After no sex, sex with a latex condom, used properly every time is the only way to reduce risk of HIV and some other sexually transmitted infections.
- Sex with a condom is not "safe sex." Sex with a latex condom is safer sex, safer than sex without a condom – but the condom must be used correctly and consistently in the right way, every single time, with all types of sex.



## Session IX- How HIV Spreads

### Session Objective:

- Enable each participant to understand how HIV can spread in a group or population.

**Time:** 1 hour

### Materials:

- Slips of paper, each with the following marks written on them: a plus sign (+), the letters “a” and “c”

### Process:

1. You may share the general objective of this set, but do not share the specific objective of this exercise, until afterwards.
2. Prepare slips of paper for each participant. Mark one with a plus sign (+), one with the letter “a” and one with a “c.” Make the markings small so they are not noticeable.
3. Distribute one to each person, noting the person to whom you gave the one with the plus sign. Do not let the group know that there is anything different about the papers.
4. Tell participants to think of three people in the group that they want to know better.
5. Tell them to walk around the group with their piece of paper and have their three people punch a hole in it with a pen or pencil.
6. Tell the person to whom you gave the paper with the plus sign to start the ball rolling. (Don’t let that person think he or she is starting off for any particular reason.)
7. When the participant (think of him or her as a peer group leader) has approached the three people and had them punch their holes, tell the rest of the peer group that they can now do the same.
8. When everyone has selected and approached their three people, tell the group to return to their places.

### Trainer’s Note

If someone approaches you, go ahead and play the game. Later on, during your comments, you can explain that although you did not intend to be a player, you went along (as most of us tend to do) taking the risk of exposure to the virus.

9. Ask the first person to stand and identify the three who punched holes in his or her paper.
10. Ask those people to stand and take turns identifying their three people.
11. Get those who are identified to stand and do the same. Carry on until all who were picked point out whom they picked.
12. Some participants may still be sitting. Ask them to identify the people they chose.
13. When the majority of the group is standing, tell them to look at their papers and see whether they have an “a” or a “c” or a “+” marked on it. Tell the people with the “a” and the “c” to step out of the circle and join you.
14. Tell the group that the person with the plus sign is HIV-positive. In real life, all the people who have had sexual contact with that person – or the people that person has had sexual contact with – could have been infected with the virus.
15. Pause for a while to let this disclosure sink in.
16. Explain that the “a” stands for “abstinence.” That person would have had contact with an infected person, but not sexual contact. That person would be safe.
17. Explain that the “c” stands for “correct and consistent condom use.” That person would be safer – not 100 percent safe, but much safer than those who took no precautions.
18. Tell the participants: “Put up your hands if you would go ahead and have sex with a condom knowing that the sex partner might be HIV infected.” Ask the group what they think about their responses.
19. Have the group sit. Pass the ribbon and have the participants say why they chose the people they did and what they think and feel about the exercise.
20. Give your own personal and general comments after everyone has spoken. There are some points below that you can also bring to the attention of the group.

### **Trainer's Note**

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Apart from your personal reflections and comments on participants' contributions, here are some other observations you may add:

1. The exercise shows that in a small community, one HIV infected person can possibly lead to the infection of a great many.
2. The exercise shows that a relatively small number of infected people in a big country like Nigeria can start an epidemic. Therefore, the HIV Sentinel Surveillance figures issued periodically by the National AIDS and STI Control Programme, Federal Ministry of Health, Abuja, Nigeria need to be taken very seriously.
3. Everyone who is sexually active is at risk – not just promiscuous people. It is not just about who “I” have sex with; it is also about who “he” or “she” has sex with, and who “they” (the partners of the partner) have sex with.
4. All of us, including girls and women, girlfriends and wives, need to start taking active responsibility for our sexual health and sex life. Only children and people who are raped may be considered “innocent” victims.
5. Too many people are still engaging in casual, unprotected sex, thereby endangering themselves and others. We can get close physically and emotionally without taking chances with sex.

## **Session X- My Most Memorable Moment Today**

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1. Tell participants, “I want you to share with the group what you were thinking and feeling during today’s session, and how you feel at this moment, now that the session has come to an end.”
2. Pass the ribbon and have participants take turns reflecting on how the day touched them.
3. Close the reflections by urging participants to begin using some of the new techniques and sharing some of the information they have gathered with those with whom they come into contact.

# Module Three

## **Values, Attitudes, Risky and Safe Behaviours and the Behaviour Change Process**

### **General Objective:**

- Enable each participant to explore values, attitudes and behaviours in a variety of situations.

### **Self-Esteem**

### **Goal-Setting**

### **Decision-Making**

### **Risky Behaviours and Safe Behaviours**

### **General Objective:**

- Enable each participant to understand what puts peers at risk from STIs and HIV and the safe behaviours that can protect them.

### **The Process of Behaviour Change**

### **General Objective:**

- Have participants understand the various stages in the process of behaviour change and what the response of a peer educator should be to a client at the different stages.

## **Session I- Reflections on Day Two**

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**Session Objective:**

- Have each participant share her or his thinking and feeling about the content and process of day two.

**Time:** 30 minutes

**Process:**

1. Tell participants, “I want you to share anything you thought about, said, felt or did as a result of the workshop during your time away from the workshop.”
2. Pass the ribbon and have participants take turns reflecting on the work of the past day or session and its impact on themselves and others.
3. Say your piece when your turn comes.

At the end of the “reflections” ask the group to say whether they have heard any evidence that learning, teaching and change has taken place among the participants.

## Session II- Values, Attitudes and Behaviours

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### Session Objectives:

- Enable participants to share and enlarge their understandings of “values” and “attitudes.”
- Enable participants to explore the myths and facts about sex and how these affect the personal and community attitudes about sex and the connections with HIV.

Time: 1 hour

### Exercise 1: What Are Values? What Are Attitudes? (15 minutes)

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#### Process:

1. Share the objective of this exercise with participants.
2. Ask participants to think about the word values, their personal values, and the values of their family.
3. After a minute or two of thinking time, organize the group into pairs. Have each person share with the partner (a) her or his understanding of values, (b) two or three personal values, and (c) two or three family values.
4. Have one person from each pair report on the group exchanges, holding back any details that may be considered confidential.
5. Repeat the process for “attitudes,” with the other partner of the pair reporting.
6. After the reporting session, apart from your general comment on the process, you might explain the two words along these lines:
  - Values can be described as what we consider worthy, worthwhile, good or have a high opinion of
  - Attitudes can be described as those beliefs and opinions that make us tend to behave in certain ways.
7. Were there important differences between personal values and attitudes and family (or parents’) values and attitudes? What accounts for some of the differences?
8. Sometimes people “talk the talk” but don’t “walk the walk.” Ask what participants think this means in connection with values and attitudes. Get participants to look at “values” separately from “attitudes” and give examples to illustrate what they think.

## Session III- Self-Esteem

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### Exercise 2: Building self-esteem

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#### Session Objective:

- Enable participants to explain the word “self-esteem” and identify factors that contribute to high or low self-esteem.

**Time:** 35 minutes

#### Process:

1. Share the objective with the participants.
2. Ask participants to think about the word “self-esteem.”
3. After two minutes of thinking time, organize the participants into pairs. Have each member in a pair (a) tell their partner how they feel about themselves and (b) tell their partner something positive about themselves.
4. Have a person from each pair share and report the group exchanges.
5. After the reporting session, explain to the participants that:
  - Self-esteem refers to the way we feel about ourselves, how we handle the way we feel about ourselves and how we handle the world.
  - How we feel about ourselves influences how others feel about us.
  - Our performance is higher when we feel good about ourselves and vice versa.
  - Our relationship with others is affected by the way we feel about ourselves.

#### Factors that contribute to high self-esteem:

- Constant positive reinforcement for our achievement;
- Supportive environment, i.e., an environment full of love, warmth and wisdom,

#### Factors that contribute to low self-esteem:

- Lack of positive environment or one with constant criticism;
- Inconsistency in the nature of one’s upbringing;
- Socio-economic instability;
- Rejection and failure.

#### Evaluation:

1. What is self-esteem?
2. List three factors that enhance the development of positive self-esteem.
3. List three factors that reduce one’s self-esteem.

## Session IV- Goal-Setting

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### Exercise 3: Defining goals

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#### Session Objectives:

- Participants should be able to define the phrase “goal setting” and explain the importance of goal setting in every day activity.
- Participants should understand the difference between long-term goals and short-term goals.

**Time:** 40 minutes

#### Materials:

- Flip chart or chalkboard, markers or chalk

#### Process:

1. Ask participants to define the phrase “goal setting.”
2. Note their responses.
3. Clarify the phrase by explaining as follows:  
Goals are proposed achievements or accomplishments towards which we direct our efforts. In every day activity we plan, and planning involves goal setting. When we plan we set goals towards which we direct our efforts.

### Exercise 1:

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1. Ask participants to divide up in pairs, with each individual writing two personal short-term goals and one long-term goal.
2. The pair members can help each other and discuss their goals with each other.
3. For each goal, they should write the time they hope to achieve the goal.
4. Specify the steps taken to achieve the goal.
5. Have each pair to report their goals and plan for achieving the goals.
6. For each goal presented, discuss whether the goal is specific, realistic and achievable.
7. After the reporting session, explain as follows:

#### Long-term goals:

These are goals meant to be achieved in years to come. For example, one might set a goal to be a tailor, an engineer, etc.

#### Short-term goals:

These are goals to be achieved very soon, such as the goal of getting enough money to buy shoes or clothes.

#### Goals must be:

- Specific to be achievable;
- Relevant and realistic;
- Time bound to be achievable;
- Quantifiable and measurable;
- Understandable and observable.



## Session V- Decision-Making

### Exercise 4: Understanding the decision making process

#### Session Objective:

- Enable participants to understand and list some steps in making a decision.
- Enable participants to describe some of the important factors considered in decision making.

**Time:** 1 hour 30 minutes

#### Materials:

- Flip chart or chalkboard, marker or chalk
- Handouts: Decision-making situation cards

Note: Prepare the situation cards before the session

#### Process:

1. Divide participants into five groups.
2. Give each group one card with one decision-making situation on it.
3. Ask the group to conduct the following exercises:

##### *Part I:*

- a. Meet and consider the situation as shown on the card.
- b. List the steps involve in making and reaching a decision.
- c. Discuss the situation and make a decision about the situation on the card.
- d. On the flip chart or chalkboard, state what decision they chose for the situation and the reason for the final decision.

##### *Part II:*

- a. Have a reporter from each group present the group's work to the larger group
- b. After the participants' responses, discuss each situation.
- c. Summarize the decision-making process and help consolidate all group ideas into one list of steps in making a decision.
- d. Explain the tools of making good decisions as:
  - a. *Self-awareness:*  
Having high self esteem helps in making good decision.
  - b. *Clarified values:*  
Understanding and being sure of personal and family values is important for good decision making.
  - c. *Information:*  
Adequate and vital information and facts about all aspects of the issue gives one the opportunity to weigh the options and make an informed decision.
  - d. *Clear values:*  
Clear values are important for determining how to most effectively use the opinions and values of others.

List other factors influencing decision making, such as religion, family, society, culture, government, policy, environment, climate, foreign influence and media.

**Exercise 5: Model for Decision Making**

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1. Ask participants to practice a simple decision-making process with the following situation.  
“I’m going to have a party. I have many friends, but because of space and expenses, I can only invite a few people. How do I decide who to invite so that no one’s feelings are hurt?”
2. Have a reporter to present the group’s work.
3. After the participants’ response, explain the model for decision making as follows:
  - a) Identification of problems: What exactly is the problem for which a decision needs to be made?
  - b) Gathering information:
    - i. Consider your personal values, goals and other facts you need to know related to the decision.
    - ii. Identify alternative solutions.
    - iii. Consider the various solutions or alternatives that could be adopted.
    - iv. Consider the advantages and disadvantages of each solution or alternative.
  - c) List the advantages and disadvantages of the various alternatives.
  - d) Choose a solution.
  - e) Plan and take action.

**Summary**

- Decision making is a day-to-day activity.
- There are many alternative solutions for every problem or situation.
- Every decision, including not making a decision, has a consequence.
- The best decision is usually one that is consistent with one’s own values.
- Better decisions result from the use of a conscious decision-making process that examines alternatives.

**Decision-Making Situation Cards**

1. You are a 20-year-old man, and you have been recently married. You and your wife are students at the university. You want to start a family, but you also want to finish your degrees and get jobs. Your wife has suggested using the loop method.
2. You are a 17-year-old girl in a secondary school. Your school anti-AIDS club has been very active lately and you have been thinking a lot about AIDS. You think that your past experiences may have put you at risk of contracting HIV, but you are afraid to know for sure. A close friend has suggested that you get an HIV test.
3. You are a 38-year-old woman, and you have seven living children. You really do not want to get pregnant again, but your husband is opposed to using the loop method.
4. Your boyfriend has been pressuring you to have sex with him. You have not decided whether or not to have sex with him. Then he invites you to come to his house by yourself.

**Exercise 6: Myths and Facts About Sex (30 minutes)**

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**Process:**

1. Divide your group into two. Divide each half into two small groups of three or four.
2. Tell the first small to come up with myths about sex and the second small group to come up with the attitudes their communities have about sex.
3. Tell the third small group to come up with facts about sex and the fourth small group to come up with community values about sex.
4. Allow about 10 to 15 minutes for this small-group work.
5. Have the four sets of groups present.
6. Have participants make a connection between any value, attitude, myth or fact about sex and its connection with HIV infection.
7. Check or double-check any sex-related fact about which you were unsure. Make arrangements to get the correct information to the person or group.
8. Close by having participants hug to the left and hug to the right.

**Trainer's Note**

- Make an exercise out of the lines in the box above by asking each person to answer the question: “What do you want from sex?”
- Then ask the people in the group who are or have been sexually active: “Do you get what you want from the sex you have (or have had)?”

**Exercise 7: Attitudes About Illness and Death****Specific Objective:**

- Enable participants to examine attitudes about death.

**Time:** 1 hour

**Process:**

1. Share the objective of this exercise.
2. Have participants discuss in pairs the attitudes people in the community have towards illness and death.
3. Stop after each attitude described to allow participants to comment or share their experiences.
4. After the last statement, ask participants to take turns saying what they felt about the exercise.
5. This exercise may be done in pairs or adapted as a written exercise.
6. You may also want to spend some time on suicide.
7. Form participants into pairs. Have pairs work on what they will do or not do when a person talks about committing suicide.
8. Participants share in plenary and facilitator adds in the usual way.

**What to do when a person talks about committing suicide:**

1. Ask direct questions in a straightforward way. For example, ask, “Are you thinking of putting an end to your life?”
2. Try and find out the seriousness of the person’s intentions by asking about the thinking and planning of the suicide. Ask about other people he or she may have spoken to. Ask about feelings and relationships. If the person does have a plan, stay close and get help.
3. Above all, listen. Be supportive and comforting without being false.
4. Encourage and assist the person to get help from a trained and reliable counselor.
5. Maintain contact after the crisis is over or after the person starts seeing a counselor.

**What not to do when a person talks about committing suicide:**

1. Do not ignore warning signs.
2. Do not refuse to talk about suicide.
3. Do not react judgmentally, with disapproval or horror.

“You need to know what it is you are wanting from sex. What that is differs for different people, but most people are searching through sex for human contact, excitement, tenderness, touch, familiarity, adventure, playfulness, a feeling of being alive in their own bodies, a renewal of confidence that they are lovable and capable of giving love. Yet many people are having sex often and getting none of these things.”

[STEPHANIE DOWRICK, FORGIVENESS AND OTHER ACTS OF LOVE]

## Session VI- Attitudes: Yes and No

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### Session Objective:

- Enable participants to examine their attitudes privately and publicly on a number of sex and sexuality issues.

Time: 1 hour

### Materials:

- Pen and paper

### Process:

1. Tell participants that you will read a number of statements. If they agree, they should write yes. If they disagree, they should write no. If they are not sure, they should leave a blank space.
2. Take one ten-statement set at a time or a session. See “Process continued” below.
  - 1) I think that sex before marriage is a good idea.
  - 2) I think love without sex between two partners is possible.
  - 3) I think sex without love is okay.
  - 4) I think sex with a child is nasty, sick and inexcusable behaviour.
  - 5) I think some women who get raped ask for it.
  - 6) I think oral sex is disgusting.
  - 7) I think anal sex is okay.
  - 8) I think that it is good to touch and stroke my own body sexually.
  - 9) If I saw two women holding hands in public, it would not bother me.
  - 10) If I saw two men holding hands in public, I would find it disgusting.
  - 1) I would feel comfortable working closely with a male homosexual.
  - 2) I would feel comfortable working closely with a female homosexual.
  - 3) If a member of my sex made a sexual advance to me, I would be very angry.
  - 4) I would feel comfortable knowing that I was attractive to members of my sex.
  - 5) I would feel comfortable if I found myself attracted to a member of my sex.
  - 6) I would feel nervous in a group of homosexuals.
  - 7) I would feel uncomfortable knowing that my daughter's teacher was lesbian.
  - 8) I would feel uncomfortable knowing that my son's male teacher was gay.
  - 9) It would bother me to discover that my doctor was homosexual.
  - 10) I would feel that I failed as a parent if my child was gay.

**Process continued:**

1. Begin by asking participants who felt uncomfortable thinking about and responding to the statements to raise their hands.
2. Ask each person to talk for a minute or two about the discomfort.
3. Ask the group if they think that girls and women feel differently or more positively about these matters than boys and men. Ask for some of the reasons.
4. Write the words yes and no in large letters and place them to the right and to the left on the floor or wall in front of the group.
5. Place a blank sheet of paper in the center, between the designated yes and no areas.
6. Tell those who indicated that they were comfortable (by not raising their hands) that you will be asking them to step forward to declare their yes or no or other positions openly.
7. If, at this stage, some participants have second thoughts, they should share them with the group.
8. Ask participants to say what they think is the purpose or objective of the exercise.
9. Ask participants whether they think it is important for trainers and peer educators to examine and openly discuss their attitudes on these matters.
10. Take the statements\* one by one and ask participants to take up their “yes” or “no” or “in-between” positions.
11. Ask the three groups now in front to consult briefly and report on the arguments and views of their group. A representative of the “I don’t know,” “it depends,” “not sure” and “others” in between should also report on the group’s thinking.
12. Conclude by asking participants to say how this exercise can help them in their peer education work.

**Trainer’s Note**

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1. Involve participants by allowing them to choose the statement or statements they want to start with or select for consideration during the session.
2. The statements can also be used singly or in pairs for discussion or to stimulate a whole group discussion.

## Session VII- Who is at Risk, Susceptible or Vulnerable?

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### Session Objective:

- Enable participants to consider various group of people and the level of risk they face and factors that increase their risk of contracting HIV.

Time: 20 minutes

### Materials:

- Flip chart
- Markers
- Trainers' handout "Who is at Risk, Susceptible or Vulnerable?"

Note: In this session, the facilitator will encourage participants to play some roles in plenary. The role-playing will be based on the characters picked among various people in the community. (Refer to list of characters on the next page.)

### Process:

1. Write on pieces of paper the description of various people in the community as provided below in the Trainers' Note (One name or description per piece of paper).
2. Have participants pick one piece of paper each.
3. If there are more participants than paper, inform the rest that their role is that of observers and they must practice their listening and observation skills by following the proceeding closely.
4. Inform participants with the pieces of paper to study their role and if they do not understand the role they should come to the facilitator for clarification.
5. Arrange the participants with papers in a row in a part of the room where there is adequate space for movement.
6. The trainer will then read out a statement, one at a time, and ask the participants who are able to do the things read aloud to step forward. Trainer continues until all statements have been read.
7. The trainer then asks observers to describe what they observed.
8. The trainer asks those on the rows to read out their characters.
9. Ask those participants who did not leave the starting point how they feel or felt as the role-playing unfolded.
10. Ask participants to define the phrase "risk, susceptibility and vulnerability to HIV."
  - A person is said to be at risk of HIV and AIDS if that person stands a chance of getting the virus by his or her behaviour.
  - A person is susceptible if, because of certain socio-economic features, he or she is at greater risk of getting the virus.
  - A person is vulnerable if he or she has a higher chance of being ill, dying or being affected by the illness or death of others.
11. Lead participants in identifying those who fall into these previous categories in their community.

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**Trainer's Notes**


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**Community Members/Roles**

Local Government Chairman  
 Minister of Health  
 General Manager, NTA Channel 2  
 Ebenezer Obey  
 Governor of Lagos State  
 Professor Atilawi, University of Lagos  
 Farmer with 100 acres in a Ife-Odan village  
 A young apprentice on an oil rig in Port Harcourt  
 Female shopkeeper in a department store  
 A female sex worker  
 A primary school girl aged 10  
 A 12-year-old girl caring for her dying mother  
 A 69-year-old grandmother caring for seven grandchildren  
 A 15-year-old boy in a refugee camp  
 A 12-year-old street child (Almajiiri)  
 A child with AIDS  
 An “area boy” with an STI

**Questions:**

Can you influence the national policy on HIV/AIDS?  
 Can you influence HIV/AIDS messages in the media?  
 Can you influence the allocation of funds for HIV/AIDS?  
 Can you control your sexual encounters?  
 Can you access health care if you have TB or STI?  
 Can you have access to grants or other social welfare services?  
 Can you get access to information on HIV and AIDS?  
 Can you get an HIV test?  
 Can you get condoms?  
 Can you get professional counselling if you need it?  
 Can you talk about HIV/AIDS?  
 Can you get poverty relief if there is such in your LGA?  
 Can you seek redress if your human rights are abused?

## Session VIII- Risk-Taking

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### Session Objective:

- Have each participant reflect on his or her own behaviour with respect to risk-taking in general.

Time: 20 minutes

### Materials:

- Flip chart
- Marker

### Process:

1. Share the objective of the session.
2. Allow each participant examine the word “risk” and define it.
3. Present a short definition of “risk” as “a situation taken that could jeopardize one’s health unknowingly.”
4. Distribute the following questions to all participants and have them anonymously answer yes or no:
  - Would you take the risk of unprotected sex with someone who is HIV positive?
  - Would you take the risk of having sex with a condom with someone who is HIV positive?
  - Would you take the risk of unprotected sex with someone whose HIV status is not known to you?
  - Have you ever had unprotected sex with someone whose HIV status you did not know?
5. Collect the completed questionnaires and count the responses.
6. Trainer summarizes that people who responded yes to each question have taken a risk and have been exposed to contracting HIV infection knowingly or unknowingly. Therefore, individuals ought to be cautious when engaging in sexual activities.
7. Ask individuals to reflect on previous behaviour that has exposed them to the risk of HIV infection.

## What Puts Peers at Risk of Exposure to HIV?

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### Objective:

- Have participants understand why different groups of people are at a greater risk of HIV infection.

### Materials:

- Pen and paper
- Chalkboard or flip chart
- Three copies of “Cultural and Psychological Factors” and “Economic Factors”

### Process:

1. Divide your group into four work groups. Explain that:
  - Group 1 will list at least 10 reasons why young boys are especially at risk from HIV infection.
  - Group 2 will list at least 10 reasons why young girls are especially at risk from HIV infection.
  - Group 3 will list at least 10 reasons why women are at particular risk from HIV infection.
  - Group 4 will list at least 10 reasons why men are especially at risk from HIV.
2. Tell the group that they will be looking at the reasons why these different groups of people are at particular risk, from four different aspects:
  - Biological factors
  - Cultural factors
  - Economic factors
  - Psychological factors
3. After allowing about 15 minutes for small group work, find out which group has the longest list and congratulate them.
4. Begin with the group with the shortest list. Have them read out their points.
5. Have the other groups list new points as usual.



6. Consult the list below to add points not made by the group. Don't read them out. Use them as talking points to get a discussion going. You can say, for example, "What about alcohol? No one mentioned it."
7. Be sure to make a note of good points made by the group.

**Young people (male and female) are at risk of contracting HIV, through:**

1. A lack of information on sex and on their bodies
2. A lack of information on sexually transmitted infections and their connection with HIV and AIDS, and a lack of relevant education and information in general
3. A lack of information and a good deal of misinformation on HIV and AIDS
4. A lack of access to HIV testing facilities. The facilities that do exist are not youth friendly. Young people who are HIV positive and do not know it pose a risk to young people who are not infected, especially in an environment like ours where young people do not accept full responsibility for taking care of themselves
5. The stigma and fears attached to HIV that prevent young people who are HIV positive from sharing this information with their peers
6. The use of alcohol and other drugs, leading to careless and risky behaviour
7. Experimentation with vaginal, oral and anal sex, all of which are risky
8. Practicing anal sex (or "homo" – trainer can substitute the local parlance) for a variety of reasons: including experimentation, not considering it real sex, preserving female "virginity," avoiding pregnancy, male homosexuality, rape, use and abuse of power by males over females; not knowing that condoms and blood vessels are more likely to break (because of the tightness of the passage), making HIV transmission more likely
9. Using sex for gaining peer group acceptance, for money and for things such as food, housing, shoes and clothing
10. Having more than one sex partner
11. A lack of information about the sexual history of partners
12. Having sex with older people who have had many sexual partners and sexual experiences
13. Risky early sex and first-time sex, because the sexual organs of young people (especially those under 18 years) tend to be physically underdeveloped; their sexual organs are therefore more likely to bruise and develop openings for HIV infection;
14. A failure of parents, guardians, religious leaders and teachers to speak truthfully and frankly to young people about sex, STIs, HIV and AIDS
15. A failure of parents, guardians, religious leaders and teachers to listen to young people, to learn what they think and know, to learn what risks they face, to encourage them to speak without fear of punishment. (Note: Many adults are unaware, unconscious of and unsympathetic to the risks young boys face from men who have sex with men and prey on children.)
16. The rejection of messages, advice and guidance from adults who are not upright and consistent in all things (not just where sex is concerned), from adults who do not respect themselves and others, from adults who abuse their bodies and the bodies of others. Young people (who do not know better) copy the behaviours of the adults who raise and teach them.
17. The increasing influence of peer groups and peer pressure, replacing adult guidance. (Note: The peer group can be a positive or negative influence.)
18. A lack of ongoing guidance and counselling in managing relationships, and coping with difficult relationships
19. A lack of self-discipline
20. A lack of responsibility to oneself and others.
21. Not having a sense that there is a personal or collective future in store
22. Immaturity
23. A lack of problem-solving skills
24. A lack of high personal standards of behaviour
25. An absence of civic and community-mindedness
26. The lack of, or low, self-esteem
27. Confusion about sexuality and sexual orientation
28. The "give it to me" and "I want it now" mentality
29. A lack of spiritual development
30. Conflicting and contradicting messages and behaviours from community and national religious and political leaders

**Process:****Biological factors:**

“Biology” is the study of life processes. Under this head, the small group will look at biological factors (with respect to HIV and the human body) that put people at risk.

**Cultural and psychological factors that affect the spread of HIV:**

Tell the “culture group” to consider the effects of race and religion, in addition to age, gender and geographic location. Make copies of this page and lend to the “culture” and “psychology” groups to make their discussion and reporting easier. Some of the things they might look at will include how the following increase the risk of HIV infection in young people: rights, roles, responsibilities and aspirations (as seen by self and as assigned by others)

**This group will need to look at:**

- young women, girls, wives, girlfriends, partners
- young men, boys, husbands, boyfriends, partners
- children generally

Also have them consider how thinking, beliefs, attitudes and behaviours of different individuals and groups affect attitudes about:

- STIs, HIV, AIDS
- sex before marriage or sex outside of marriage
- sex with sex workers (prostitutes)
- anal sex (penis to behind), oral sex (penis to mouth or mouth to vagina), or penis to vagina sex
- multiple partners
- homosexuality, same-sex relationships, bisexuality
- sexual health
- talking about sex and sex education (in the family, in school)
- blood transfusion
- alcohol and other drug use
- condom use
- rape, incest
- the beating of children
- violence against women
- childbearing and child rearing
- birth control, pregnancy, abortion
- communication in the family
- the right of children to information and to hold and express opinions
- suicide, death, after-life
- reverence for the sacredness of life
- the nature of God
- sin and punishment
- truth and goodness
- feelings and responsibility towards oneself, family, community and country

**Economic factors affecting the spread of HIV:**

We suggest that you also give the “economic” and “psychology” groups a copy of this page. The psychology group will appreciate that one’s economic situation and expectations affect we think about ourselves, risk behaviours and HIV. The opposite is also true. How we think about ourselves shapes our attitudes towards money, possessions and risk behaviours.

This group will need to look at:

- individuals (young men and young women, separately), from
- different families and types of households, in
- different sections of different communities in towns, villages and hinterland communities, and in
- Nigeria as a whole

They should also consider how economic factors affect the following topics and can lead to the spread of HIV among young people:

- Education facilities (general, HIV and AIDS, STIs, sexual and reproductive health)
- Public and private health care (as above, facilities for HIV/STI testing, treatment for opportunistic infections and diseases)
- Counselling facilities for HIV and AIDS, for those infected and affected, for suicide, alcohol and drug use and domestic and other violence
- Information on the spread of HIV
- Condom availability and information on its correct use
- Hotlines
- Employment opportunities for people with and without skills, and acceptable levels of formal education for the healthy and for HIV-positive people
- Childbearing and childrearing
- Use of sex for money, acceptance, housing, food, footwear, fashionable clothes and other body wear
- Migration (cross-border, interior and country to town, overseas)
- The sense of future prospects for individuals, a community and one’s country

**Psychological factors affecting the spread of HIV among youths:**

“Psychology” is the study of mental processes and the emotional and behavioural characteristics of an individual, group or activity. This group will focus on the thinking, language, feelings and behaviours of individuals, in and outside peer groups, in different family, cultural, social and economic situations.

## Session IX- High Risk, Low Risk or No Risk?

### Session Objective:

- Assess each participant's awareness of the risks of HIV infection associated with certain behaviours.

Time: 45 minutes

### Materials:

- Four large sheets of paper with the following headings:
  - High-risk behaviour
  - Low-risk behaviour
  - No risk behaviour
  - Don't know

### Twenty "behaviour cards" with the following statements:

- Having sex after getting "high"
- Having many sexual partners
- Having sex with a "good" person without a condom
- Having sex with a virgin
- Sex with a condom
- Mouth-to-penis sex (oral sex)
- Mouth-to-vagina sex (oral sex)
- Penis-in-the-behind sex (anal sex)
- Using a condom with wife or partner, but not with others
- Using a condom with others, but not wife or partner
- Kissing
- Using a public latrine
- Exposure to mosquitoes
- Having sex with a commercial sex worker
- Caring for someone who has AIDS
- Drinking from a glass used by someone who is HIV positive
- Sleeping in the same bed with someone who is HIV, but without having sex
- Getting a tattoo
- Giving blood
- Hugging

### Process:

1. Organize your group into a circle with the four large "Risk" sheets of paper in the middle.
2. Distribute behaviour cards, one card per person.
3. Tell participants to take turns placing his or her card on the selected "Risk" sheet and give reasons.
4. After each person reads out and places his or her card, invite the group to agree, or disagree and give their reasons.
5. Ask someone in the group to help out, in the event of any "don't know" responses.
6. Correct and/or give additional information where necessary.
7. Ask the person who received the last card on the list, "How did the language used strike you?"
8. Use the opportunity for a group discussion on language and behaviours in peer education work.
9. Tell the group that this exercise was intended to get them thinking, talking and moving around issues of risk-taking and relationships, sex and HIV.
10. Tell the group that it also helps the educator to learn how much participants already know about how one can and cannot get HIV, and about safe and safer sex. Based on their clients' response to questions such as those below, the clients can assess their own risk to STIs and HIV:
  - Are you sexually active?
  - Have you ever contracted an STI?
  - Do you currently have an STI?

- Have you treated your STI?
- How many sexual partners do you have?
- Do you use condoms consistently?
- Are you practicing mutual fidelity with your partner?
- How many sexual partners does your partner have?
- Do you practice oral sex?

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**Trainer's Note**

This exercise can be used at the beginning of a workshop, at the beginning of the sessions (or modules) that focus on risk or behavioural change, or as a stand-alone activity to reinforce or assess (pre-session or post-session) participants' knowledge of behavioural risks associated with HIV.

## **Session X-**

### **The Role of Alcohol and Drugs in HIV Transmission**

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**Session Objective:**

- Give participants an opportunity to think about, describe and learn from one another about handling peer problems with alcohol and drugs.

**Time: 30 minutes**

**Process:**

1. Share the objective of this exercise with the group.
2. Ask each participant to imagine a situation where a peer approaches a peer educator about a problem with a boyfriend who drinks or does drugs.
3. The participant should focus on either alcohol or another specific drug – specifying the type of alcohol or drug and preferably one the peer educator knows about – and explain to the group how to go about handling the situation.
4. Have participants evaluate and offer suggestions on each other's handling of the situation with the peer.
5. Have half of the group discuss, in pairs, the connections between alcohol use and abuse and STIs, including HIV.
6. Have the other half discuss, in pairs, the connections between drugs (users, sellers, and family members of the two groups, separately) and STIs and HIV.
7. Have one person from each pair report to the group.
8. Ask the group to think about, and discuss in pairs, those things that would have come up if the exercise had the peer concerned that “My girlfriend drinks and does drugs.”
9. Ask for feedback from the pairs on their thinking.
10. Ask for comments from the group about whether the exercise achieved its objectives.

## Session XI- Understanding Behaviour Change

### Session Objective:

- Have participants understand the various stages in the process of behaviour change.

Time: 1 hour

### Materials:

- Flip chart and markers or chalkboard and chalk

### Process:

### Exercise 1:

1. Ask participants to think of any behaviour change in their lives. They can think of areas such as smoking, religious practice, alcohol or drug use, study or food habits, dress.
2. List the areas they come up with down one side of the flip chart.
3. Ask a few people to describe, step-by-step, why and how they changed their behaviours. Ask about cultural, health, information, partners, peer group, friends, family and other factors. List reasons for the change next to each behaviour area.
4. Ask the group to look at the similarities and differences that came up as participants spoke of the reasons for making a behavioural change.
5. Use the heads below to group the reasons:
  - Received additional information
  - Influence from parents
  - Influence from peers
  - Services and/or commodities were available
6. Take one of the examples and chart it along the Behaviour Change Process outlined below. Relate “influences” and “services” noted under #5.

### THE PROCESS OF BEHAVIOUR CHANGE

**Unaware**

**Informed**

**Concerned**

**Knowledgeable**

**Motivated to change**

**Ready to change**

**Trial/assessment of new behaviour**

**Sustained behaviour change**

7. Ask if anyone is able and willing to share a behaviour change experience connected to STIs or HIV and walk the group through the chart above.
8. Lead participants in identifying the peer educator’s response should be to a client at each of the stages of behaviour change.

STAGES OF BEHAVIOUR CHANGE	RESPONSE OF PEER EDUCATOR TO A CLIENT AT EACH STAGE
1. Unaware	Provide basic information on situation, such as the causes and consequences of untreated STIs.
2. Informed	Encourage them to adopt positive steps and present them with behaviour change options.
3. Concerned	Tell them what to do next in changing their own behaviour, such as going to the clinic to receive STI treatment.
4. Knowledgeable	Motivate the client to act, for example, by informing them of the benefits of attending clinic.
5. Motivated to change	Point or direct client to services and encourage their use.
6. Ready to change	Tell client the benefit of using the services.
7. Trial assessment of new behaviour	Provide an opportunity to practice new skills and reinforce what the client will do to continue the new behaviour.
8. Sustained behaviour changed	Tell the client they are doing the right thing. Create an environment that promotes the new behaviour.

## Exercise 2: Belief as a Factor in Behaviour Change

### Specific Objective:

- Lead participants in appreciating how strong the influence of belief can be in behaviour change.

Time: 30 minutes

### Materials:

- Flip chart and markers or chalkboard and chalk.

### Process:

- Let participants explain the term “belief.”
- Let participants respond “yes” or “no” to the following questions. They should put their answers on a sheet of paper but not write their names.
  - Do you think you may be infected by HIV?
  - Do you think your partner may be infected by HIV?
  - Do you consider AIDS to be a deadly condition?
  - If you are infected with HIV, will it adversely affect your life?
  - Do you think condoms can prevent AIDS?
  - Do you find it easy to get condoms?
  - Can you or your partner wear the condom correctly?
- Collect each participant’s sheet of paper.
- Divide the participants into 5 groups.
- Let a member from each group pick any of the scripts submitted and discuss the responses to each question.
- Let the spokesperson of each group present their opinion on the possible consequences of the answer to each question.
- Let the other groups agree or disagree with the presenter’s opinion.

Note: The trainer should study the “Health Belief Model,” taking note of the basic elements of the model.



### Exercise 3: Enabling Factors in Behaviour Change

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**Specific Objective:**

- Lead the participants in appreciating some positive factors that foster behaviour change in individuals.

**Materials:**

- Flip chart and markers
- Chalkboard and chalk

**Time:****Process:**

1. Let each participant list one factor that enables behaviour change.
2. Collect each participant's answer and write it on the flip chart.
3. Lead a discussion on each enabling factor given by the participants.
4. Divide the flip chart into three columns with the following headings:
  - Effective communication
  - Creating an enabling environment: policies, advocacy
  - User-friendly, accessible services and commodities

Ask a participant to pick each factor supplied by the participants and read aloud. Let another participant write the factor under the most appropriate column. The group should agree on the appropriate column for each factor.

Note: Trainer should consult the FHI "Programming Behaviour Change" diagram

## **Session XII- How to Motivate and Support Behaviour Change in Others: Peer Educators at Work**

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### **Session Objective:**

- Enable participants to try out and improve peer education communication skills.

**Time:** 1 hour

### **Process:**

1. Organize participants into two groups of ten each.
2. One participant from each group should pick a paper with one of the roles below written on it or be assigned to play one of the roles below:
  - a. A truck driver who is concerned that he may have an STI
  - b. A secondary school student who is considering abstinence
  - c. A sex worker who is trying to sustain condom use but is concerned about losing her clients
  - d. A housewife who suspects that she has acted in risky manner by having multiple sexual partners, one of whom she has heard is HIV positive
  - e. A father who wants to talk to his teenage children about STIs, HIV and AIDS
  - f. A teacher in a village school who wants to stop smoking
  - g. A single parent who wants to try the female condom for her active sexual and social life
  - h. A community leader who is considering a policy to ban child marriage in his domain
  - i. A polygamous man who wants to introduce mutual fidelity among his wives
  - j. A female student who wants to stop dating her lecturer
3. Ask a participant from the second group to pair with another from the first group and play the role of an STI/HIV peer educator at work in each group.
4. Allow peer educators to show how they will motivate or support the behaviour change.
5. Participants should give feedback in plenary.
6. Ask peer educators and other group participants to report along the following lines:
  - How effective were the communication and motivation strategies?
  - What techniques were used to get and hold attention?
  - How did peer educators decide which people to concentrate on?
  - What were the responses like?
  - How did it feel?
  - What were you (the peer educator) thinking at the time?
7. Allow all participants the opportunity to play the peer educator role in sets of five.
8. At the end of each role-playing session, stop and process the encounters along the lines indicated above.
9. Call a time-out and reassemble in your circle.

### **Trainer's Note**

Adapt this exercise for individuals with a variety of different backgrounds and spots frequented by your peer educators, e.g., female sex workers (FSWs), PLHA, adolescents (both sexually active and not sexually active).

# Module Four

**Communicating Effectively as a Peer Educator**



## Session I- Daily Reflections

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### Session Objective:

- Have each participant share her or his thinking and feeling about the content and process of an earlier day.

Time: 15 minutes

### Process:

1. Tell participants, "I want you to share anything you thought about, said, felt or did as a result of the workshop during your time away from the workshop."
2. Pass the ribbon and have participants take turns reflecting on the work of the past day and its impact on them and others since.
3. Say your piece when your turn comes.
4. At the end of the "reflections," ask the group to say whether they have heard any evidence that learning, teaching and change has taken place among the peer educators.

## Session II- Overview of Effective Communication

### Session Objectives:

- Have participants understand the component of effective communication so that at the end of the session they will be able to:
  - Define communication;
  - Identify types of communication;
  - Identify the elements of effective communication;
  - Understand and explain the concept of “noise” in the communication process;
  - Explain basic communication bridges.

Time: 1 hour

### Exercise 1: Relay the Message

Time: 10 minutes

#### Process:

1. Ask for six volunteers.
2. Inform the large group to keenly observe the role-playing and to note their impressions of what transpired.
3. Let one of the volunteers stay in the “class”, while the remaining five go out.
4. Read out a message to the first volunteer (the one remaining in the room), such as “Tomorrow I will be going to the market. On the way, I’ll call on my sister to discuss many family issues which have been pending for some time,” or any complex statement, and let him or her relay it to the second volunteer who comes in a little while later. Have the second volunteer relay the message to the third and so on until the final volunteer gets the message.
5. Ask the last volunteer to repeat the message as he or she heard it.
6. Have the first volunteer read out the initial message.
7. Ask the participants to identify in plenary those factors that contributed to the distortion of the messages as it was relayed.
8. Note participants’ responses.
9. Ask participants if they considered the communication effective in the role-playing.
10. Request that participants define what is considered an effective communication.
11. Note their responses and lead a discussion on their definitions, paying attention to relevant points. Share a prepared flip chart with the following lines:

### Exercise 2: The Components and Elements of Effective Communication

Time: 15 minutes

#### GOOD COMMUNICATION MEANS

Showing genuine interest

Expressing openness and understanding

Listening to the problem and what brought it about

Staying quiet when talk is not needed

Thinking through a problem carefully and sharing ideas, instead of seeking quick-fix solutions

**Materials:**

- Felt pen
- Tape
- Flip chart

**Process:**

1. Ask participants to list the components and elements of an effective communication.
2. Ask participants to explain the role and importance of each component.
3. Review participants contributions and clarify as appropriate.
4. Ask participants to describe the elements and components of effective communication using examples from peer educators activities. In this:
  - a. the sender is the peer educator;
  - b. the receiver is the peer client;
  - c. the message is "Condom use and prevention of STIs and HIV infection";
  - d. the channel is through the use of a chart;
  - e. the feedback is the return message from the client that he now knows the reasons for condom ineffectiveness and understands his motivation to try condom use again.
5. Summarize the session by making the following additional statements about the components and elements of effective communication:
  - a. Message: The message must be clear, concise, factual, simple and timely.
  - b. Sender: Appropriate message must be sent to specific target.
  - c. Channel: An effective and culturally acceptable channel must be used to reach the receiver.
  - d. Receiver: The receiver must be able to read and understand the message sent and internalize and interpret it as intended.
  - e. Effect: There must be positive change in the behaviour of the target or receiver. If this does not happen then the message has no effect on the receiver.
  - f. Feedback: The receiver must be able to say whether the message was appropriate, timely and effective. If this component is missing, then the cycle is not complete.

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**Exercise 3: Are They Communicating?**

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**Materials:**

- Pieces of papers and pens

**Time: 10 minutes****Process:**

1. Ask for five volunteers.
2. Give each volunteer a piece of paper containing different messages such as:
  - It is so cold in here that I am shivering.
  - The traffic today was terrible.
  - I have just received a sad message.
  - I saw a man whipping a little boy with a belt.
  - My exam result is out and I passed with flying colours.
2. Let each volunteer stand in front of the group and act out the message on his or her piece of paper without speaking.
3. Discuss how easy it was to understand each volunteer.
4. Ask what type of communication participants' observed in the exercise.
5. Lead a discussion on the different types of non-verbal communication.
6. Ask participants what they know of non-verbal communication as a type of communication.
7. Lead the participants in identifying the various communication skills that will help the peer educator in his or her work.
8. Discuss the skills suggested by the participants.

9. Explain the following skills to the participants if they were not mentioned in their suggested communication skills:
  - Speaking skills
  - Listening skills
  - Attending skills
  - Observing skills
  - Questioning skills
10. Inform participants that these skills will be developed through various exercises the peer educators will be undertaking in the course of the day.

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#### Exercise 4: Let's Consider Noise in Communication

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Communication is the process through which a message is transferred from one person to another or from one group to another, and involving feedback. Communication can be verbal or non-verbal. Verbal involves the use of sound. In non-verbal, gestures and facial expressions are used.

**The major elements in communication are:**

- Message
- Sender
- Channel
- Receiver
- Feedback
- Effect

Noise in the communication process is anything that affects the communication process. Noises are sometimes referred to as barriers to communication. These barriers may not always be a regular noise, like the horn of a car or the shouts from a motor park. Noise can come in through the various elements in the communication process. Examples of noise include:

- Language barrier
- Ambiguity in message
- Distorted or incomplete information
- Sender's mannerisms
- Long sentences
- Wrong pronunciation or a difference in accent
- A sender's or receiver's state of mind, such as whether they are anxious or nervous
- Age
- Culture, e.g., mode of dressing
- Interruptions

To neutralize noise and promote effective communication, the sender must take into consideration some essential bridges such as:

- Choosing a good time to talk
- Understanding the context in which the message is set or sent
- Developing active listening skills and other communication skills
- Being patient
- Seeking feedback
- Accepting the rights of others to hold values and come from cultures different from yours

Listening actively to feedback can help the sender gauge how well the issues under discussion are being understood. As those training to be peer health educators, we should try as much as possible to develop our listening skills.

Communication is the main tool the peer educator has in the discharge of her or his duty. Peer educators must be skillful in the art of communicating effectively. Their listening skills, as well as other communication skills, have to be well developed.

Listening skills can be divided into two types:

- Passive listening
- Active listening

In passive listening, you are silent and allow the person to talk. Your interest and concern are expressed in a non-verbal form.

In active listening, you make the sender understand the thoughts and feelings of their messages by describing your impressions of what has been said.

The acronym **ROLES** helps us remember the steps taken to ensure active listening:

- Relax
- Open up
- Lean forward
- Establish eye contact
- Smile when appropriate

**Attending skills** can come in the form of acknowledgements. We can use brief expressions that express our understanding and acceptance of what is being said with such phrases as “I see” and “O hoo.”

Attending skills are remembered through the acronym **CLEAR**:

- Clarify by asking something like “Did you say you are feeling good?”
- Listen with non-verbal expressions such as nodding
- Encourage by saying something like “Go on, I am following,”
- Acknowledge by saying something like “That’s O.K, I see, I hear that.”
- Repeat what someone has said to you.

**Questioning skills** at times may come in form of door openers. Here you are not actually asking direct questions. You can use expressions which invite the person to talk more, such as “I would like to hear more about that” or “Tell me more about it.”

**Observation skills** can develop more in the area of paraphrasing the content of what you have just heard to confirm accuracy and understanding.

**Speaking Skills** are often remembered with the acronym **KISS**: Keep It Simple and Short.



## Session III- Peer Education as a Behaviour Change Communication (BCC) Intervention

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### Exercise 1: The Concept of Peer Education

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#### Session Objective:

- Lead participants in understanding peer education.

#### Materials:

- Flip chart and markers
- Chalkboard and chalk

Time: 20 minutes

#### Process:

1. Share the objective of this session with participants.
2. Let someone explain the word “peer” to the group.
3. Lead the participants in considering the meaning of peer, as explained by a participant, and come to an agreement.
4. Let another participant explain the meaning of education.
5. Lead participants in considering the meaning of education, as explained by a participant, and come to an agreement.
6. Let each participant write two advantages of peer education.
7. Write the advantages of peer education, as given by the participants, on the flip chart (Avoid repeating the same opinion).
8. Lead participants in discussing each advantage.
9. Lead participants in explaining these statements:
  - To teach is to learn twice.
  - To teach is a far more primitive urge than to learn

### Exercise 2: Criteria for Selecting Peer Educators and Peer Educators’ Services

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#### [Session or Specific?] Objective:

- Lead participants in identifying the special qualities expected of a would-be peer educator.

#### Materials:

- Flip chart and marker
- Chalkboard and chalk

Time: 1 hour

#### Process:

1. Share the objective of the session with the participants.
2. Have participants write three qualities that they will look for when selecting people to be trained as peer educators.
3. Have participants exchange what they wrote with the person nearest them.
4. Call each participant to read aloud what he or she has on the paper. Get another participant to write these qualities on the flip chart as they are called out.
5. Lead the participants in discussing these qualities. Add whichever ones you think are left out and allow the participants to discuss it.

### **Exercise 3: Evaluating the Input of Peer Educators**

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**Specific Objective:**

- Lead participants in understanding what duties are expected of peer educators and in finding a way to ascertain the extent of their performance.

**Time: 1 hour**

**Process:**

1. Divide the participants into four small groups.
2. Let each small group suggest two main works they expect peer educators should perform.
3. Collect and write each group's answer on the flip chart.
4. Get the whole group to agree on the duties as suggested by of the small groups.
5. Redistribute the agreed-upon list of duties among the four small groups and let each one come up with how effectively the duties can be performed.
6. Let the spokesperson of each group present the results in two minutes.
7. Other groups may ask questions and contribute.

## Session IV-

### **Approaching a Peer and Beginning a Conversation**

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#### Session Objective:

- Enable participants to try out, improve and gain confidence when approaching a peer to begin a conversation.

Time: 1 hour for each set up

#### Materials:

- Items from the peer educator tool kit

#### Exercise 1: Waiting For the Trans-P

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##### Process:

1. Share the objective of this exercise.
2. Organize your group as if they are at a particular bus park at a time. For example, the bus stop or motor park will be orderly with a line of empty waiting buses, drivers at the wheel and conductors hanging around. One bus may be loading. The motor park may have two or three partly filled buses, drivers at the wheel and conductors hustling passengers. And so on.
3. Everyone can be involved in this exercise, as bus operators, passengers or itinerant vendors.
4. When your bus stop or motor park has been set up, identify and send peer educators to work on starting a conversation that can lead to some aspect of STI/HIV prevention.
5. Allow about 15 minutes for the peer educators to get their act together, make contact and conclude a session.
6. Re-gather and analyse the encounters.
  - How effective were peer educator sessions?
  - What techniques were used to get and hold attention? How effective were they?
  - How did peer educators decide which people to concentrate on?
  - What were the responses like?
  - How did it feel?
  - What else did participants observe?
7. Repeat for different situations. Adapt for boat and river-crossing point settings, at parties, in a drinking place, relaxing under a tree.
8. Ask participants to say whether this exercise helped them to gain confidence in engaging members of the public in a discussion about HIV.

## **Exercise 2: Presenting Clear Information and Receiving Feedback**

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### **Specific Objective:**

- Enable participants to appreciate the essence of presenting clear information and requesting and receiving verbal feedback.

**Time:** 20 minutes

### **Materials:**

- Flip chart and markers

### **Process:**

1. Ask participants to list factors that may make a verbal message unclear.
2. Remind them that:  
If a message is too complex, vague, unclear or too long it may not produce the desired effect. It might, in fact, lead to a misunderstanding or misinformation. Every peer education verbal effort must conform to the advice contained in the acronym KISS.
3. Ask participants to explain feedback.
4. Help participants understand the importance of feedback in communication by stating that:  
Feedback is essential in the communication process. Until the sender gets feedback on a message, he or she has not yet communicated. It is the responsibility of the sender to capture the feedback. This will let the sender know the timeliness, appropriateness and effectiveness of the communication.
5. Explain the guidelines for receiving feedback:
  - Ask the receiver his or her understanding of your message.
  - Listen actively to the words being said, those things unsaid (non-verbal messages) and the real meaning behind the words.
  - Either repeat the message, if not understood, or thank the receiver if the message was understood.
  - Find out what “noise” disturbed the message if it was not received accurately.
  - Do not be defensive, angry or irritated.
  - Try to send the message through other channels or by removing the “noise.”

### **REMEMBER**

The purpose of interpersonal communication is to understand and be understood.

6. Form participants into pairs.
7. Let them practice giving information and receiving feedback in different peer education situations as per the following:

### **Trainer's Notes**

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Ideas for conducting role-playing (Participants should be encouraged to develop more case scenarios.):

- A friend told you that somebody said it is dangerous to hug an HIV-positive person.
- A girl has approached you and wants to know if it is safe to re-use a condom.
- Your friends were arguing about the practicality of abstinence and you came into the room.

### Exercise 3: Active Listening

#### Specific Objective:

- Enable participants to assess and improve their peer educator communication skills.

Time: 45 minutes

#### Process:

##### Exercise: The Peer Educator and JJC

1. Draw aside two members of the group and put the following situation to them for acting out in a role play:  
A peer educator and JJC run into each other. The peer educator is excited about the HIV prevention-training workshop last week. The peer educator starts telling JJC about it. JJC asks a question about HIV. The peer educator doesn't hear, but keeps chatting away. JJC tries three, four, five times to get a word in, but without success. Finally, JJC shuts up.
2. While the two players are getting ready, organize the other participants into small groups of four or five. After the role-playing, ask each small group to answer the following questions and appoint one person to report.
  - What was happening during the role-playing?
  - Does this sort of thing happen a lot? Why?
  - What can this lead to?
  - What can the peer educator do to improve his or her communication skills?
3. Set up the following role-playing situation and repeat the discussion and reporting process as before:  
JJC approaches a peer educator and starts talking about a problem with STIs. The peer educator interrupts and starts telling JJC about risk behaviours and how to prevent STIs. JJC listens politely for a while, gets restless and then says that the problem is treatment, not prevention. The peer educator says, "Oh, you have an STI!" and starts telling JJC where to go. JJC gets fed up and walks off with loud teeth-sucking. The peer educator follows saying, "What is the matter with you? I was just trying to help."
4. Set up this role-playing situation and repeat discussion and reporting process as before. However, instead of the last question, ask what good communication skills were used in this case.  
Peer educator and JJC meet. JJC expresses concern about STIs. The peer educator listens attentively and asks a few questions about points that were not clear. JJC gets a little embarrassed. The peer educator gives JJC some silent time to recover. The peer educator reaches out in a comforting way. JJC looks relieved, and relaxes. The peer educator begins to help JJC think about some ways to work through the problem.
5. Organize your group into pairs (peer educator and peer) and have each pair come up with a few short role-playing activities where effective communication skills are demonstrated. Each member of the group should take turns being a peer educator in a role-play. Encourage participants to choose a difficult rather than an easy situation, and a situation they have experienced or are likely to experience.

#### GOOD COMMUNICATION MEANS

**Showing genuine interest**

**Expressing openness and understanding**

**Listening to the problem and what brought it about**

**Staying quiet when talk is not needed**

**Thinking through a problem carefully and sharing ideas, instead of seeking quick-fix solutions**

6. After each role-playing, have the group (and the peer) participate with you in assessing the communication skills – oral and body language – of the peer educator.
7. All participants should have an opportunity to play the peer educator role.

8. If you wish, have group pairs rate the performance of the peer educator on a scale of 1 to 10. Each pair should use the checklist below to help them decide how many marks out of ten to award the peer educator. (The points are a short form of the list above.)

1. Interest
2. Openness
3. Listening
4. Silence
5. Thinking/Ideas

*Or with*

- Relax
- Open up
- Lean forward (or use non-verbal encouragers such as nodding)
- Establish eye contact
- Smile or remain silent as needed

9. After the assessments are shared, the group should propose to the peer educator how he or she can improve their communication skills.
10. Conclude by asking each participant to say how they benefited from the exercise.

## Session V- Behaviour Change Communication (BCC)

### Strategy in Peer Education

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#### Session Objective:

- Lead participants in understanding behaviour change communication strategy (BCC) in peer education.

Time: 30 minutes

#### Materials:

- Flip chart or chalkboard
- Marker or chalk
- FHI/IMPACT handout

#### Process:

1. Familiarize participants with the objective of this session.
2. Ask a volunteer among the participants to explain the behaviour change communication strategy.
3. Lead the participants in considering the meaning of the BCC strategy as explained by the volunteer and come to an agreement.
4. Have participants write two BCC strategies that they will use in peer education.
5. Note: make sure that the participants do not repeat same strategies.
6. Lead participants into explaining how each strategy mentioned can be used in peer education.
7. Ask questions to identify difficulties and assess participants' understanding of activities.
8. Summarize and emphasize the main points.

#### Trainer's Note

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BCC has many different but related roles to play in HIV and AIDS programming. Effective BCC strategy should:

- Increase knowledge by making sure that people have the basic facts about HIV and AIDS in the language or medium they understand.
- Promote essential attitude change. It can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, greater openmindedness about gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS.
- Stimulate community dialogue on the underlying factors that contribute to the epidemic, such as risk behaviour, risk setting and the environment that creates these conditions.
- Promote advocacy to ensure that policy makers and opinion leaders approach the epidemic seriously. Advocacy takes place at all levels, from the local community to the national level.
- Reduce stigma and discrimination through effective communication on HIV and AIDS.
- Promote prevention, care and support services that address STIs, orphans and vulnerable children (OVC), voluntary counselling and testing (VCT) for HIV, the reduction of mother-to-child transmission (MTCT), support groups for people living with HIV and AIDS (PLHA), clinical care for opportunistic infections and social and economic support. BCC strategy improves the quality of these services by supporting providers' counselling skills and clinical abilities.

#### **Exercise 4: Arguments for Abstinence**

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**Session Objective:**

- Enable each participant to explore abstinence as a lifestyle choice.

**Time: 25 minutes**

**Process:**

1. Share the objective of this exercise with the group.
2. Ask participants to discuss in pairs the meaning of the word abstinence.
3. Bring the group together and ask for the different meanings that came up. Try to reach consensus with the group on a working definition of abstinence.
4. Ask those in the group who are in favor of abstinence to stand.
5. Rearrange the seating arrangement in the group so participants who are in favor of abstinence are seated together, facing the others across the circle. Leave a gap between the two groups.
6. Pass the ribbon and allow those who were not in favor of abstinence to have their say.
7. After each person in that group has spoken, ask the pro-abstinence people to share their views. Ask those who are now practicing abstinence, or who have practiced it in the past, to share their experiences.
8. Close by asking each person to say who was able to communicate a pro-abstinence position most effectively, and why.

#### **Exercise 5: Assertiveness and Refusal Skills**

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**Specific Objective:**

- Help participants develop the ability to cope with situations requiring assertiveness and refusal skills

**Time: 25 minutes**

**Materials:**

- Flip chart
- Markers
- Strips of paper with role-playing scenarios

**Process:**

1. Ask participants to discuss what assertiveness and refusal means in the context of sexual and social relationships and encounters.

Assertive behaviours and communications are those in which an individual states his or her opinions on an issue in a clear manner without being rude or putting the other person down.

Refusal skills are those communications and behaviours that tell someone that you do not want to do a particular thing. This involves clearly saying “no” and acting in ways to confirm this position, but bearing in mind that you should not fuel anger or frustration in the other person.

2. Ask two participants to describe situations when they have had to assert themselves or refuse an offer or suggestion they considered harmful or unacceptable.
3. Form participants into threes where one person is the sender of an unacceptable message, the other is the receiver of the message and wants to assert himself/herself and the other is an observer.
4. Give each group a paper on which a role-playing idea is written as per examples below.
5. Allow participants to practice in their small groups exchanging roles and deciding approaches that they considered most effective
6. Allow 10 minutes for role playing.
7. Reassemble your group in plenary.
8. Lead a discussion on the lessons the participants have learned.
9. Encourage participants to practice assertiveness and refusal from now on.



**Trainer's Note and Role-Playing Ideas**

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A boyfriend and girlfriend are hugging. He says to her, "Let me go in from the back. Nothing will happen. Nobody will know. You can't get pregnant like that."

A man drives up and stops at the corner. He calls out to his neighbor's daughter, who is standing with her friends. "Come, let me drop you at home." She says, "No. It's alright." Her friends say, "Go, girl."

A man drives up and stops at the corner. He calls out to his neighbor's son, who is standing with his friends. "Come, let me give you a ride home." The son says, "No. It's alright." His friends say, "That is the big man we were just talking about. He likes boys. You just have to say what you want. Go, and you'll see!"

"We have to use a condom. I went to the clinic and they say I have an infection," one partner says to the other. "Condom? Condom? I don't want to hear about a condom! I want to hear about how you got infected!"

Her boyfriend returns to the coast after spending three months in the bush. He gives her a gold chain and a ring. He says, "It's been a long time. I can hardly wait. Let's go now."

She has been feeling "not too good." She thinks she may be pregnant and goes for a test. After the examination, the nurse tells her that she is pregnant and has a sexually transmitted infection. The nurse says she should take a test for HIV.

## Session VI- Relationship Skills

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### Session Objectives:

By the end of this session, participants will be able to:

- Identify typical “lines” people use to pressure others for sex;
- Respond appropriately to those “lines”;
- List effective responses to common “pressure lines.”

**Time: 1 hour and 30 minutes**

### Materials:

- Small slips of blank paper
- A watch or clock with second hand
- Flip chart or chalkboard for scoring
- Markers or chalk

List of “pressure lines”:

- Everybody is doing it.
- If you truly love me, you will have sex with me.
- I know you want to – you’re just afraid.
- Don’t you trust me? Do you think I have AIDS?
- Girls need to have sex; if not, they develop rashes.
- We had sex once before, so what is the problem now?
- But I have to have it.
- If you don’t have sex with me, I won’t see you anymore.
- Girls need to have sex; boys give them vitamins (to make their breasts grow).
- If you don’t, someone else will.
- Practice makes perfect.
- You can’t get pregnant if you have sex only one time.
- You don’t think I have a disease, do you?
- But I love you. Don’t you love me?
- Nothing will go wrong. Don’t worry.
- But we are going to get married anyway. Why not just this once?
- Aren’t you curious?

### Exercise 1: Developing life skills, such as making appropriate decision and thinking through the consequences

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#### Process:

1. Arrange participants into teams of four.
2. Make room for the judges to sit.
3. Ask the teams to create names for themselves.
4. Write the names of each team on the black board or flip chart.
5. Explain to the teams that you have collected a list of different pressure lines people might use to get their partner to have sex.
6. Read the “pressure lines.”
7. Explain to the team that they have two minutes to answer each question.
8. The team will agree on their response and write it on the slip of paper.
9. Time the teams and call out when the time is up.
10. Collect the slip of paper and read them aloud to the whole group. (Make it lively.)
11. Give the slips of paper to the judges.
12. The judges will have one minute to declare the winner. (Judges will award two points to the winner and zero to the loser.)

13. Write the score on the score board and repeat the process with the next pressure line.
14. When the lines are exhausted, tally up the score and announce the winner.
15. Give a small prize, if you can.

**Processing the pressure lines (15 minutes):**

Spend two minutes after the game to process the exercise. State the importance to participants as follows:

- a) It helps young people to hear the common lines people use when they want to have sex.
- b) Hearing these lines in this game brings them close to a real situation. This enables them to overcome such pressure when it appears in real life situations.
- c) The cumulative responses from different participants in the teams offer a variety of ideas a person can use in an actual situation.
- d) It is helpful to the participants to think about these lines before being in a passionate or pressured situation.

**Evaluation (5 minutes)**

Quickly go round the room and ask participants to state the response they would most likely use in a pressure situation

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**Exercise 6: Talking To Groups (Asokoro/Wuse)**

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**Specific Objective:**

- Enable participants to try out and improve their peer education communication skills while on the move.

**Time: 25 minutes**

**Materials:**

- Condom
- HIV ribbon
- “Ready Body” or other HIV/AIDS handout

**Process:**

1. Share the objective of exercise with participants.
2. Organize chairs or benches in the center of the workshop space to resemble a minibus seating arrangement. Organize your group in the manner of a fully loaded (or over-loaded) minibus on the Asokoro/Wuse II route in Abuja.
3. Ask four volunteers to be the first peer educators on the bus: one in the front seat to take on the driver, one next to the conductor, and one each for the other two rows of passenger seats.
4. Arm each peer educator with a condom, a ribbon and a Ready Body handout or any other HIV/AIDS handout.
5. As soon as peer educators take their seats, they are to begin a conversation that can lead into a discussion on some aspect of STI and HIV prevention. Tell them that when you give the signal for the bus to move off, they will have approximately the same time as it takes the bus to turn around.
6. Agree on the time period together.
7. The passengers are free to leave the bus when they get to their stops. Others in the group, who are not in the bus, may stand and observe or join the bus when a passenger gets out.
8. Signal the full bus to take off.
9. When the time is up, signal the bus to stop.
10. Have participants return to the circle and comment on the effectiveness of the peer educators’ communication.
  - What techniques were used to get and hold attention?
  - How did they work?
  - How did peer educators decide which passengers to concentrate on?
  - What were the responses like?
  - How did it feel?
  - What else did participants observe?

### Trainer's Note

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1. Repeat the exercise with different peer educators for different short routes. All players, peer educators and others, should take on the culture, occupation and characteristics of the bus operators and passengers of particular routes: the Southeast/Southwest, East/West, North/South and so on. The time allotted should be the approximate time of a one-way trip. Agree on "pretend" times for long trip destinations such as Onitsha/Abuja; Kano/Onitsha; Abuja/Lagos, etc. Adapt for use on ferries and speedboats.
2. Spend some time on techniques for getting discussions started. Talk about how peer educator tool kit materials can be used. Here are a few tips on conversation openings:
  - Newspapers open at pages with pictures or stories of assaults, murders, suicides, obituaries, HIV or AIDS statistics, violence to women or children
  - References to any of the above that appeared in paper, on radio or TV, or happened in community
  - Questions about how road deaths might compare to AIDS deaths in numbers; about whether they teach about the pathogenesis of the virus at health facilities; about whether sex education is going on in the person's school; about whether the person is telling his children about HIV.
  - Coming up with real or imaginary friends, as in: "I have this friend who is a minibus driver," or "I have this friend who has a minibus conductor boyfriend," or "My friend's son . . ."
  - Volunteering information about real or imaginary situations: "I'm going to the clinic to . . ."; "Did you hear about . . ."; "I just came from an HIV workshop and . . ."; "Look at this . . ."; "Last week a girl in the scheme . . .".
  - Seizing on someone or something connected with the person being approached: "You are looking good! I hope . . ."; "That's a nice earring . . ."; "That's a cute baby! How old . . ."; "Every time I see a baby, I . . .".

### Exercise 7: Condom Negotiation Skills

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#### Specific Objective:

- Equip participants with condom negotiation skills for use in peer education.

**Time: 2 hours**

#### Process:

1. Ask whether there is anyone in the group who is sexually active and using condoms.
2. Ask those people whether they are willing to share with the rest of the group how they negotiated (or worked out) condom use in the relationship. That is, how the subject came up, who proposed it, what happened, how it went, how it is going, and so on.
3. Ask whether any people in the group have tried to bring up the issue of condom use, but failed. Ask them to share their experiences.
4. Organize the group into threes. Ask each trio to come up with one situation (being as realistic as possible) where condoms should be used. They should then come up with a strategy for a partner to introduce condom use. The strategy should anticipate possible resistance by the other partner.
5. After about 7 to 10 minutes, ask one person from each trio to describe the situation they were working on, and the strategy they decided on.
6. Here are some tips on condom negotiation you can share:
  - Say no to sex without condoms – clearly and directly.
  - State firmly and clearly that your life and health are more important than the sexual relationship.
  - Ensure that partner has condoms and is willing to use them – or is willing to use condoms you have – before any sexual activity gets started.
  - Persuade your partner that you will make putting on and using a condom very exciting.
  - State your reasons for refusing sex without a condom in a firm manner.
  - Tell your partner that, in addition to your concern for your own safety, you are concerned about his or her safety.
  - Have condoms readily available.
  - Propose other ways of having sexual pleasure without penetrative sex.

- Ask someone with influence to intervene.
  - Always be conscious of situations you may not be able to handle and wherever possible, avoid them or have a well-thought-out escape route.
7. Ask pairs to demonstrate condom negotiation skills (using some of the tips above) through role-playing of the following situations:
    - Where one partner is “under the influence or alcohol” or “drunk”
    - Where one partner is high on a drug other than alcohol
    - Where one partner is older, in a male same-sex relationship
    - Where one partner is older and male, in a male/female relationship
    - Where one partner is known to be violent
    - Where money or gifts are offered for sex without a condom
    - Where the male partner is being aggressive
    - In a first-time sexual relationship
    - Where a girlfriend introduces condom use to a long-time boyfriend
    - Where a boyfriend introduces condom use to a long-time girlfriend
  8. Have the group examine each role-playing performance thinking about the effectiveness of the communication skills of the person negotiating condom use.
  9. Have participants take turns saying what they thought about the exercise and what they learned from the exercise.
  10. Have each participant mention some arguments in the community against condom use.
  11. Review the list of arguments and look at which are myths or false.
  12. Provide information on proper condom use and condom effectiveness.
  13. Have participants take turns saying how this exercise can be useful in peer education work, especially as it relates to the promotion and distribution of condoms.

### Exercise 8: Condom Relay

1. Ask for nine volunteers for a condom relay race. Give each person a condom and a penile model or plantain.
2. Divide the nine into three teams of three. Have them stand in three lines, three-deep, facing the rest of the group.
3. Place one plantain on the ground in front of each team.
4. At the signal, the first person from each team will run forward, extract the condom from the packet, fit condom correctly on the plantain, remove it, tie it and run to the back of the team.
5. The second person then moves forward to do the same.
6. Then the third person does the same, bringing the relay to a finish.
7. Have the audience judge whether the condoms were fitted, removed and tied properly and which team won.

Tell me, I will forget.  
Show me, I may remember.  
Involve me and I'll understand.

[Chinese proverb]

**Tips on correct condom use:**

- Condoms are made of rubber. Heat weakens and destroys rubber, so condoms should not be kept in back pockets and wallets or any place where they are exposed to heat (this includes body heat) or the sun. They should be kept in a cold or cool place until they are to be used. Pay attention to the expiration date or the date of manufacture on the packet. An old (over five years) or expired condom can break during sex. Two condoms do not offer double protection; rubber rubbing against rubber creates friction that will cause breakage.
- Use latex condoms. Stay away from flavored or chemically treated condoms designed for oral sex and other purposes. The chemicals can affect the rubber and cause it to be porous, leading to the possible seepage (in or out) of viruses that may be present. They can also bruise the tender tissue of the vagina walls. Bruises create openings through which viruses and bacteria can enter. Do not rub any oily or greasy stuff on condoms; this will weaken the condom and cause it to break.
- Remove the condom carefully from the packet, making sure it is not punctured accidentally.
- The tip of the condom should be squeezed when it is being put on. This keeps the air out and leaves space for the semen after ejaculation. The condom can burst if the penis or air gets into the tip. Place condom on an erect penis and roll it all the way down.
- After sex, remove the condom carefully, but before the penis gets soft. Hold it at the base and make sure that no semen spills. If you have been grating coconut or cassava, make sure you have no cuts on your hand, because the virus from an infected partner can enter into your system through such cuts.
- Tie the condom and put it in a covered garbage container. Do not flush it down a toilet, as this could block the toilet.

## Session VII-

### Using Print, Video and Picture Code Materials

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#### Session Objective:

- Enable participants to assess and make the best use of communication materials available to them.

**Time:** 30 minutes

#### Materials:

- Samples of materials used

#### Process:

1. Have participants show (or refer to) the print materials used and describe their use, according to the 5 Ws and 1 H method of enquiry. Write up the six question words and prompt responses along the following lines:
  - Who uses this material? (trainer, facilitator, peer educator by gender, age and experience) With whom it is used? (by age, gender, education level, group size)
  - When is it used? (times, points in sessions, for how long) When is it not used?
  - Where is it used? (in what situations, locations, organized or chance encounters, in-school, street work)
  - What is it used for? What process follows its use? What response follows its use? What results follow its use? What behaviours follow its use? What might work better? What can be substituted for results that are as good or better?
  - Why is it used? (In other words, what is the point or purpose?) Is the purpose served by its use? Is it essential to your purposes?
  - How were users trained in the use of the material? How is it used? How is it not used? How is it useful? How is it received? How can it be better used?
2. Invite comments and recommendations from the group. Make your own comments and recommendations.
3. Repeat the process for other materials used. Include condoms as a communications material.
4. In the process of thinking through the use of all of their materials in this way, participants can understand the importance of process in planning, using and following up – immediately as well as in the short-, medium- and long-term.

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#### Trainer's Note

If handouts are only handed out, videos only viewed, role-playing only played and picture codes displayed with no thought to the who, when, where, what, why and how (that is, the process) of their use, the effectiveness of these materials will be limited.

#### Condom distribution questions to consider:

- Are they for protected sex that night?
- Are they to be placed in handbags or pockets for use when the situation arises?
- Are they to be tried out on the recipient's organ in the privacy of the home?
- Are they to be used as discussion starters?
- Are they intended to cause confusion in the home when a suspicious partner stumbles on them?
- Are they for instructing children and other members of the household in correct condom use and correct condom storage?
- Are they to be used as playthings?

To make the best use of the condoms distributed, purpose and process must be addressed before and during the workshop. Participants should be given suggestions. For example:

- Take this and show your friends how to use it.
- Use this to talk to your husband, boyfriend, partner or child about safe sex.

### Viewing of an STI or HIV Video

After viewing the video, ask participants for their comments along these lines:

- What did you see? What problems came up?
- What are the various things that led to the problems?
- What did (or can) the problems lead to?
- What would you suggest? (Short, medium and long term solutions)

### Using Picture Codes

A picture code is a visual presentation of a problem, situation or issue familiar to the person or group. It raises questions. It is intended for stimulating discussion and getting answers and solutions. For example, a picture code might depict:

1. A middle-aged man sitting in his car, strokes the thigh of a schoolgirl in uniform. They are parked outside a short-time place.
2. A school-aged girl, in the early stages of pregnancy, walks past her old school. A group of students in uniform, about her age, are looking at her.
3. A schoolboy is dropped off around the corner from an orphanage by a big man. The schoolboy's brand-name boots are obviously new.
4. A schoolgirl in uniform is sitting in the office of a doctor known for performing abortions.
5. A man is sitting on his back steps showing a condom to three youths.
6. Four young men leave a party late, but stop to pick up a young woman waiting for a taxi on the road.
7. A minibus pulls up. The driver invites the girl standing by the road to come sit in front. She is, as the song says, "a girl with a front-seat face."
8. A mother discovers a sportswear outfit in her daughter's school bag.
9. A woman is cleaning up and getting ready to do the wash. She finds a condom in her partner's pocket.
10. A man in a police uniform is shouting at and threatening a woman. She is covering her face and crying.

The picture is presented and questions along these lines are posed:

- What do you see happening here?
- What are the various things that lead to this?
- What is the STI/HIV connection here?
- What other problems can follow?
- What would you suggest?

You might want to try imaginary picture codes, with participants visualizing scenes.



## Session VIII-

### Sustainability of a Peer Education Programme

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#### Session Objective:

- Lead the participants in understanding possible approaches that will ensure sustainability in peer education.

#### Exercise 1: Defining Sustainability and Identifying Key Stakeholders in Peer Education (45 minutes)

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##### Process:

1. Share the objective of the exercise with the participants.
2. Lead the participants in explaining what sustainability means.
3. Let the participants name certain projects they have seen, heard of or participated in that are either still functioning or no longer functioning.
4. Participants should give reasons (or suggest reasons) for the status of project they mentioned.
5. Let someone act as a secretary during this exercise and write down the points made.
6. Divide participants into four groups
7. Let each group come up with a list of five stakeholders in a peer education project and think of how these major stakeholders could be a support or an hindrance to the project
8. Let each group present and justify the stakeholders on their list.

#### Exercise 2: Specific Strategies of Sustainability of Peer Education Programmes

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##### Specific Objective:

- Lead participants in suggesting specific efforts to enhance the sustainability of a peer education programme.

Time: 45 minutes

##### Process:

1. Form participants into two groups.
2. Tell the groups to identify factors that can hinder effective peer education and propose innovations to improve peer education.
3. Participants present in plenary.
4. Fill in the gaps as per the trainer's note and discuss other issues of sustainability.

#### Trainer's Note

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Factors that hinder effective peer education:

- Lack of resources to get the message out (materials, transport, etc.)
- Poor grasp of a community's language
- Lack of skills to create innovative messages and presentations
- Lack of personal motivation (both peer educators and their clients), due to a lack of materials and the means to do their jobs
- Socio-cultural and religious factors

Proposed innovations to improve peer education:

- Use a participatory methodology that lets clients decide the way and manner in which they get information.
- Explore cost-sharing and networking with other NGOs.
- Use the appropriate local language in presentations and materials.
- Carry out continual evaluation of the modes of communication.
- Provide incentives and opportunities to motivate peer educators (such as participation in conferences, workshops, etc.)
- Enlist the support of opinion leaders and influential people in the community.

**Issues of sustainability:**

- Ownership
- Incentives
- Training or re-training for sustainability
- Adaptability of the curriculum
- Community-based approach
- Economic empowerment
- Coherence versus incoherence
- Clearly defined goals and objectives
- Capacity building
- Coordination and networking
- Managerial process: a management information system that includes feedback on the activities of peer educators
- Direct involvement of peer educators in all aspects of the programme
- Multi-sectoral approach and integration with other sectors
- An integrated communication approach
- An enabling environment

# Module Five

**Care and Support for People Living with HIV and AIDS**



## Session I- Daily Reflection

### Marking Time: Empathy and Dealing with Stigma

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**Session Objective:**

- Have each participant receive the H, I or V mark and talk about it.

**Time:** 25 minutes

**Materials:**

- Red felt-tip marker

**Process:**

1. Go around the group and, using a red marker, write either the letter H, I or V on the palm of each participant's hand. Write H on the first person's palm, I on the next, V on the next, H on the next, and so on until each person is marked.
2. Ask participants to study the mark and listen to what it says to them about the virus.
3. Have participants take turns describing their mark and saying what was going through their minds and their hearts, what they were thinking and feeling, while studying it.
4. Draw attention to how people with HIV are marked and feel marked. Point out that the original meaning of the word "stigma" is a "mark on the skin made by cutting, branding, burning, pricking or puncturing," drawing blood and therefore red.
5. Conclude the activity by having participants cross their arms across their chest, hug themselves, close their eyes and make a silent wish.

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## Session II- I Am a Peer Educator. Who Am I?

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### Session Objective:

- Enable participants to see and speak of themselves as peer educators.

### Materials

- Pen and paper

Time: 1 hour

### Process:

1. Remind peer educators about the overall objective of the IMPACT project and the “Care to Live Healthy” campaign. Share the general objective of this final set and the specific objective of this exercise.
2. Have each participant think of 10 responses to the statement and question “I am a peer educator. Who am I?” Give them 5 minutes to make a note of their answers.
3. Go around the group and have each person share their 10 answers with the rest of the group.
4. Ask the group to take a second look at their lists and see how many additional answers to the “Who am I?” question they can find. Get participants working on this assignment – sharing and extending their lists – in pairs with the people closest to them.
5. Have one person from each pair share what the two got out of the pair work.
6. Ask a few participants to volunteer to assess the benefit of this exercise in front of the group. What did they learn about themselves? What did they learn about each another? What did they learn about being a peer educator?
7. Bring this exercise to a close by telling the group that peer educators need to pay constant attention to themselves and keep increasing their self knowledge – for their own sakes and so that they can reach out to others in a helpful and non-judgmental way.

## Session III- What Are the Roles and Responsibilities of a Peer Educator?

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### Session Objectives:

- Participant will understand what they can do as peer educators.
- Each participant will examine the factors involved in handling responsibility and, in the process, develop the ability to handle responsibility.

Time: 45 minutes

### Materials:

- Flip chart, markers and papers

### Process:

1. Ask participants to reflect on all the sessions completed so far during the training.
2. Allow 2 to 3 minutes of individual reflection. Inform participants that they may jot down any things, lessons, issues, etc., that come to mind.
3. Reveal a prepared flip chart with the phrase "An HIV and AIDS Peer Educator is . . ."
4. Request that each participant complete the statement either in writing or mentally. Allow for 2 minutes to do this.
5. Go around the group asking the participants to read out loud or say their statements.
6. Capture the participants' definitions.
7. Form participants into four groups.
8. Each participant should list out five roles and five responsibilities that are expected of an HIV and AIDS peer educator.
9. Have a representative from each group read out their list, not repeating whatever has already been said. (Be sure to remind participants to practice their listening skills.)
10. Lead a discussion on the roles, their importance, and how peer educators can perform these roles effectively.
11. Add roles from the list of roles below if they have not been mentioned.
12. Participants should brainstorm in pairs the meaning of the word "responsibility."
12. Ask them to come up with other related words.
13. Participants will present their lists. Note responses.
14. Write the word "responsibility" in large letters on a flip chart and below it write the phrase "Response Ability".
15. Discuss "responsibility" as "the ability to respond" or "being able to respond."
16. Ask participants to look at factors that affect how we handle responsibility. These should include:
  - belief in ourselves
  - desire to make change
  - desire to be different
  - desire to accept burdens
  - being able to accept what we have been taught
  - discipline, i.e., being able to forgo a pleasure now for a good future
18. After some feedback on the items above, add your own comments. Explain how discipline, with respect to eating, exercise and abstinence or responsible sexual behaviour, prepares one for a better and good life.
19. Pass the ribbon and have all participants say how they feel about coping with their responsibility.
20. End this exercise by having participants close their eyes and offer a silent prayer for the strength and ability "to respond and keep on responding," wherever and whenever, until HIV infection becomes a thing of the past.

**Trainer's Note**

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**Roles and Responsibilities of a Peer Educator**

- Educating peers on STIs and HIV in one-on-one and small group sessions
- Assisting peers to access condoms, STIs and voluntary counselling and testing (VCT) services
- Participating in HIV outreach awareness and other public events
- Reporting on their peer education work
- Upgrading peer educator skills and planning for peer education work
- Supporting PLHAs' efforts in living positively
- Distribute educational materials
- Train other peers
- Hold regular meetings
- Teach peers to negotiate safer sex
- Sell condoms (not for the primary and secondary in-school projects)
- Teach peers how to do a personal risk assessment
- Teach peers about home care for PLHAs
- Provide referrals to health care facilities

## Session IV-

### What It Means to be a Volunteer Peer Educator

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#### Session Objective:

- Initiate participants into the concept of volunteerism and its relevance to peer health education work.

Time: 45 minutes

#### Materials:

- Flip charts, markers and tapes, or chalk, mobile chalkboard and duster

#### Process:

1. Lead the participants in explaining the term volunteer.
2. Group participants into four and let each group identify projects that were undertaken locally through volunteers' efforts. They should also explain how they were carried out. The projects may be in the following settings: churches, mosques, schools, towns, medical centers, security posts, offices, etc.
3. Let each group present to the larger group for discussion.
4. Re-group the participants into four and let each group brainstorm on any of the following:
  - How volunteerism can be of benefit to the peer education programme
  - The need for volunteers in peer education programme
  - Factors that may hinder volunteerism in peer education programme
  - How the gains of volunteerism can be maximized in a peer education project
5. Let each group present to the larger group. Encourage discussion of each presentation in plenary.

#### Trainer's Note

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Volunteerism can be explained as the act of willingly engaging in a wholesome cause beneficial to the society without the intention of making profit. In this explanation of volunteerism, three major elements are important:

- The cause must be positive or wholesome. Volunteerism is associated with desirable endeavor.
- Individuals must not be forced into taking part.
- The intention in taking part in the activity should not be to make profit.

#### Advantages of Volunteerism in Peer Health Education:

- Volunteerism encourages more people to be involved in the peer education activities and, as a result, more people can be reached with health messages.
- It is cost effective.
- Since peers are the volunteers, their peers will be willing to listen to them and be more receptive to messages.
- There is also a sense of belonging when nobody sees himself or herself as the employee or the employer.

Efforts should be made to prevent the following factors which may reduce volunteerism's effectiveness in peer education:

- Poverty versus commitment
- Waste of resources
- Continuity problems



## Session V-

### **What Do I Need to Take to and Bring Back from My Work?**

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#### Session Objective:

- Have participants think about and plan what they need to take to and bring from their peer education work.

#### Materials:

- Pen and paper

Time: 2 hours

#### Process:

1. Share the objective with the group.
2. Organize your group into pairs.
3. Each pair will answer the following two questions, taking into consideration the situation and work of both individuals in the small group:

What do I need to take to my work?

What do I need to bring back from my work?

4. Tell participants to listen carefully to each group to see whether the pair-group have covered everything and whether they can learn anything.
5. In your remarks after the presentations, stress the importance of taking the following things to peer education work:
  - Quality, character, integrity, honesty, truth, dependability, love, respect, leadership, confidentiality and a positive, cheerful and non-judgmental attitude
  - Reliable information, handouts, condoms and other physical things in and out of the peer educator tool kit.
6. Emphasize the importance of bringing back from peer education work:
  - Reliable and accurate reports according to the agreed guidelines, stories of successes and failures and anything that can guide and improve future work.
7. Pass the ribbon so that each participant can have an opportunity to say whether she or he has the necessary information, materials and confidence to proceed or continue with HIV prevention work. If, for any reason, items are missing, spend some time on alternatives and/or make a note to remedy the situation as soon as possible.
8. Close by reviewing reporting guidelines and indicating when and where the next follow-up training session will take place.
9. Some of the items that may form part of the report are repeated below. Consult the section on peer education for closing remarks.
  - Name of peer educator
  - Age
  - Address and telephone number
  - Name and location of school or workplace
  - Reporting period
  - Locations of peer education work
  - Estimate of hours spent on peer education work during reporting period
  - Number of one-on-one sessions with peers
  - Ages
  - Number of males
  - Number of females
  - Number of people met with incorrect or inadequate information on STIs/HIV/AIDS
  - Number of those people who now have correct information
  - Number of people who understand the significance of the window period
  - Number of small-group sessions held
  - Number per session
  - Ages

- Males
  - Females
  - Number of males and number of females reporting that they have started using condoms
  - Number of males and number of females reporting using condoms with those who are not their regular partners
  - Number of males and number of females deciding on abstinence
  - Number of males and number of females who report that they will wait for the person they want to spend the rest of their lives with before becoming sexually active
  - Number of males and number of females who have used an STI or VCT site
  - Best (or rewarding) experiences doing peer education work
  - Worst (or bad) experiences doing peer education work
  - Signature of peer educator and date
10. Organize a commitment or recommitment ceremony to bring your workshop to a close.

## Session VI-

### Human Rights Issues in HIV and AIDS Peer Education

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#### Session Objectives:

- Each participant will identify the human rights of people living with HIV and AIDS (PLHAs).
- Participants will become aware of their roles in upholding the human rights of PLHAs and educating others to do the same.

Time: 45 minutes

#### Materials:

- Four case study guidelines for analysis, flip chart and markers

#### Process:

1. Present the session topic.
2. Ask participants to define or explain the term “human rights.”
3. Note their responses and clarify as follows:
  - “Human rights are certain things people should enjoy because they are human beings”.
  - Human rights are the benefits that people should enjoy no matter who they are, where they are from or what they have.
4. Lead participants to identify some human rights
5. They should include:
  - a. The right to live
  - b. The right to shelter
  - c. The right to employment or a means of a livelihood
  - d. The right to education
  - e. The right to healthy living
  - f. The right to have protected sexual intercourse
  - g. The right to marry
  - h. The right to family life
  - i. The right to dignity
  - j. The right to body integrity and safety
  - k. The right to seek redress in court if maltreated because of sero status
  - l. The right to participate in economic activities, including obtaining a loan to set up a project (socio-economic support)
  - m. The right to health care without discrimination
  - n. The right to freedom of worship
  - o. The right to vote and be voted for
  - p. The right to freedom of speech
6. Ask participants if people in the community are aware of these human rights and if they uphold them. Note their responses.
7. Inform participants that people who are weak, poor or disadvantaged in any way often have their human rights infringed upon or abused. People living with HIV and AIDS often have their human rights abused.
8. Form participants into four groups. Depending on their level of literacy, either distribute to everyone in a group the case studies below or have someone read and explain the case studies.
9. Participants should analyse the cases by answering the questions in the case studies.
10. Have participants present in plenary the results of their analysis.
11. Lead a discussion on the roles and responsibilities of a peer educator in upholding PLHA human rights and in advocating for others to do the same.

### **Trainer's Note**

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#### **Case Studies:**

- A. Bala, a factory worker, was forcefully ejected by his landlord after he was found to be HIV positive, despite having paid six months rent in advance.
- B. Miss Angela belongs to the religious sect that does not permit the taking of blood from the human body for any reason. As a result of her failing health, her employer suspects that she might have been infected with HIV. Angela is now given an ultimatum of two months to go for HIV test or lose her job.
- C. Benjo and Maria have been married for ten years with children. Maria tested positive to HIV and told her husband about it. The husband's family forcefully ejects her out of her matrimonial home and takes the children to an unknown place.
- D. Bisola has been admitted to a general hospital with a twin pregnancy. On discovering that Bisola is HIV positive, the doctors and nurses start discriminating against her. When it was getting close for her to be put to bed, the hospital authorities gave excuses to discharge her, forcing her to go home for her care.

#### **Questions:**

- 1. Identify the human rights infringements in each case.
- 2. What steps can you as a peer educator take to affirm the PLHA's human rights?
- 3. What other issues can result from not upholding the rights of these individuals?

## Session VII- Basic Home-Based Care Techniques

### Session Objective:

- Enable each participant identify some common HIV and AIDS symptoms and provide information on how to treat them.

**Time:** 45 minutes

### Materials:

- Flip charts, markers

### Process:

1. Have participants list the common problems AIDS patient encounter.
2. Jot down their responses.
3. Organize their responses into seven major sections:
  - Nutrition
  - Infection control
  - Skin problems
  - Fevers and pain
  - Cough, difficulty in breathing
  - Sore mouth and throat
  - Diarrhea
4. Let participants go into seven groups and assign a section to each group. Allow them to work on this for 5 minutes. The participants should state clearly how to carry out basic care at home.
5. Present the outcomes of group work in plenary.
6. The facilitator should clarify and include the following if not mentioned during presentation:
  - ***Provide good nutrition:***
    - Examine the source of income.
    - Conduct a market survey to know foods that are high in protein, available in the community and their cost.
    - Plan the food within the family income.
    - Help the person with hygiene and personal care.
    - Always wash hands with soap and water before cooking, eating and after going to the toilet and coughing.
    - Wash clothes, linens and cloth with soap and water.
    - Dispose of urine and faeces in the toilet or burn in a container. \*Avoid contact with blood and other body fluids and wash hands with soap and water immediately after handling soiled articles
    - Always wear gloves before handling any body fluids.
    - Wash open sores with soap and water, and keep the area dry.
    - Use slightly salted water as a disinfectant.
    - For rashes, apply local remedies and oils, such as coconut oil or calamine lotion.
    - Gently rub skin that is dark, reddened or irritated.
    - To prevent bed sores, change the patient's position every two hours if the patient is too weak to do so.
  - ***Sore mouth and throat:***
    - Rinse the patient's mouth with warm salt water four times daily.
    - Have the patient suck pieces of ripe tomatoes or a lemon for thrush if it is not painful.
    - Have the patient eat soft foods that are not too spicy.
  - ***Fevers and Pains:***
    - Wash the patient's body in cool, clean water or wipe the skin with wet cloths.
    - Have them drink a lot of water, tea, broth or juice.
    - Remove thick clothing and blankets.

- *Cough or difficulty in breathing:*
  - Cover mouth when coughing.
  - If the person has a bad cough lasting more than 3 weeks, refer them to health worker to rule out tuberculosis or pneumonia.
  - If the patient develops a new fever and chest pain, encourage the patient to see a health worker.
  - Keep windows open to allow for fresh air.
  - Keep client in a sitting position, whenever possible, to encourage easier breathing.
- *Diarrhea:*
  - Treat immediately to avoid dehydration by using oral rehydration salts or homemade sugar and salt solutions.
  - Ensure copious fluid intake.
  - Continue eating frequent regular meals, such as mashed bananas or porridge.
  - Wash the buttocks and anus with warm soap and water after each bowel movement and keep the skin clean and dry.

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## Session VIII- Difficult Questions and Difficulty Situations

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### Session Objective:

- Enable participants to answer difficult questions and deal with difficult situations.

Time: 45 minutes

### Materials:

- Pen and paper
- Newsprint or chalkboard

### Process

1. Introduce the specific objective of this exercise. Make the point that because of the difficulties others have faced and their failure to stop the increase of HIV infection in Nigeria and the rest of the world, peer educators have been recruited for this work.
2. Have participants write down the three most difficult questions they have faced, or expect to face, in their work.
3. Have participants share their questions. As each question is shared, ask those who have been faced with it to raise their hands.
4. Write the questions up as they are read out. Note the frequency with which each particular question or issue arises.
5. As each question comes up, ask participants who think they have good answers or ideas to share them. Confirm, correct, add or substitute as necessary, but only after you have given the group an opportunity to learn from each other. Be sure to lead a round of applause for especially creative solutions.
6. Repeat exercise for “difficult situations.”
7. Close the exercise by telling group that joint problem solving is one of the real values of a participatory approach to education. Tell them of the “two ideas” African proverb.

## Session IX- What If I Need to Refer My Peers?

### Session Objective:

- Explore with participants the steps taken when peers need help that peer educators can't supply.

Time: 30 minutes

### Materials:

- Pen and paper
- Chalkboard and chalk or flip chart and markers

### Process

1. Organize participants into four small groups of four or five individuals.
2. Ask two groups to do the following:
  - Make a list of the needs that a person who tests positive might have.
  - List the benefits of being referred to others for help ("others" may include people and organizations).
3. Ask the other two groups to do the following:
  - Make a list of the needs that a PLHA might have.
  - List the services (help) that people and organizations might be able to offer.
4. Have each group report on their group findings. During the discussions on the group reports, add points from the list that follows, where and when necessary.
5. Ask participants to get back into their small groups and look at these two questions:
  - What important things should a peer educator do before referring a peer?
  - What important things should a peer educator do after referring a peer?
6. Add points from the notes below during the discussion following the group reports.
7. Write up the five main steps in referring (see notes) and review with peer educators.

### Trainer's Note

Although this Guide is about STI/HIV prevention, there may be situations where someone with an STI or who is HIV-positive or who is living with AIDS (a Person Living With AIDS or PLHA) may approach a peer educator or be referred to one.

This exercise will equip peers with the skills to make "referrals." The points below have been adapted from a "Referral Protocol" intended for counselors of PLHAs.

Emphasize the importance of confidentiality, getting the agreement of the peer before referring him or her, and following up with the peer after.

#### **FIVE STEPS IN REFERRING PEERS TO OTHER FOR ASSISTANCE**

1. Find out peer's needs.
2. Discuss with peer the benefits other people, agencies and organizations can offer.
3. Be confidential. Do not talk about the peer's situation. Defend the peer from idle talk. Seek and get an agreement from the peer before approaching others.
4. Make the contact and set up appointment for peer.
5. Follow up and, if necessary, try something else sharing ideas, instead of seeking quick-fix solutions.



**The Five-Step Referral Process:**

1. Find out peer's needs. They may include the following:
  - Counselling, for peer, for a partner or for the family
  - Specific and detailed information on STIs, HIV, AIDS and treatments
  - Health care and medical interventions for STIs, HIV and AIDS-related infections and diseases
  - Support, such as nutrition (good food and supplements), housing, finances, childcare, foster care and adoption for children, care for other dependents (for example, an elderly, ill or disabled person dependent on the peer)
  - Help in finding out what services exist and how to apply for assistance
  - Basic home care
  - Institutional care
  - Family planning
  - Spiritual and religious support
  - Crisis or information hotline
  - PLHA support group
  - Self-help or self-reliant projects
  - Human rights protection

2. A peer educator and the peer can work together to match the peer's needs with help from others (individuals, inside and outside the peer's support group, institutions and agencies that are both governmental and non-governmental) can offer and discuss benefits. Benefits may include:
  - Practical assistance in the form of financial support, medication, housing, home care;
  - Specialized services, such as counselling, family planning, information and legal aid on adoption; and
  - Long-term support.

**Note:** Using the technique of the Relationship Map (Set 7, Exercise 7), a peer and a peer educator can examine all the connections and resources from which they may be able to access help.

3. Seek and get agreement from the peer before talking to someone else. The two most important points in this regard are the following:
  - Seek the peer's consent before referring or bringing in others.
  - Protect the confidential information and identity of the peer.
4. Make the contact and set up appointment for the peer:
  - Make calls and help fill out any forms required for the peer to get the service or support needed.
  - Let peer know the date, time, place and the name of the person or agency .
  - Make an appointment to see the peer for feedback.

**Note:** A peer who is HIV positive, has an STI or is living with AIDS often needs this kind of assistance (handholding) to get help that is available.

5. Follow up. After the peer has been referred to someone or someplace for assistance, the peer educator may need to do the following:
  - Inquire or talk about the results of visit.
  - Find out whether the peer is satisfied.
  - Find out whether the peer needs to be referred elsewhere, and follow #3 and #4 guidelines again.
  - Above all, maintain contact. Do not abandon your peer after the referral.

## Session X- Developing an Action Plan

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### Session Objectives:

- Obtain information from peer educators about their plans and let them know what is expected of them.
- Develop proper documentation of proposed target figures.
- Develop a monitoring and evaluation plan.

**Time: 1 hour**

### Materials:

- Flip chart and markers

### Process:

1. Let the group in plenary identify:
  - The target audience for their peer education activities; and
  - Some sexuality and reproductive health behaviours among the audience which may expose them to contracting STIs or HIV.
2. For about five minutes, discuss the characteristics and behaviours of the target audience as revealed by the project's in-depth assessment.
3. Divide participants into four groups and assign each group the task to generate a list of activities they as peer educators will undertake in their communities to prevent the spread of STIs and HIV.
4. Have the participants' group representatives present in plenary with contributions from the larger group.
5. Reveal a prepared flip chart listing "Activities Expected of HIV and AIDS Peer Educators" as per the checklist below.
6. Review the list and use it to fill in the gaps not covered by participants' presentations.
7. Request that each participant or team develop an individual or team plan of action on how they intend to carry out activities in the community.
8. Have participants present the plans in plenary and receive peer and facilitator feedback on the feasibility and creativity of their plans.
9. Close the session by reminding participants the importance of these plans and of following them and reporting back to the NGO.

## Session XI- Post-Workshop Questionnaire

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### Session Objective:

- Assess the level of change in participants' knowledge and skills during the course of HIV and AIDS peer education training.

**Time:** 30 minutes

### Materials:

- Questionnaires

### Process

1. Settle participants down.
2. Distribute copies of the questionnaire for literate groups but be prepared to conduct oral structured interviews with non-literate groups.
3. Allow time for the completion of the questionnaires and interviews.
4. Collect questionnaires and thank the participants.

### Trainer's Note

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This is an optional activity for non-literate groups. Other qualitative assessment procedures may be followed. Find below some sample questions for the questionnaire:

1. State four advantages in knowing what STIs are and their effects on the ready body.
2. Name the seven body shapers.
3. List three major differences between HIV and AIDS.
4. Explain three reasons why it is important to know the difference between HIV and AIDS.
5. Explain the window period.
6. State three reasons why it is important for people to know about the window period.
7. What reasons can you use to encourage people to undergo VCT?
8. What four situations will make you recommend VCT to a client?
9. State four behaviours that can put a person at risk of HIV.
10. List the seven stages in the behaviour change process.
11. Name four communication skills that can help a person prevent himself or herself from contracting STIs and HIV.
12. Who is a peer educator?
13. List five qualities of a good peer educator.
14. List five roles of an HIV and AIDS peer educator.
15. What are three basic needs of PLHAs?
16. Name three important records to be kept by a peer educator.

## Session XII- Final Workshop Evaluation

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### Session Objective:

- Receive feedback from the participants on various aspects of the workshop.

Time: 30 minutes

### Materials:

- Markers
- Flip chart
- Papers

### Process

1. Inform participants of the session objective and its importance.
2. For a literate audience, administer the final evaluation questionnaire.
3. For a non-literate audience, employ qualitative evaluation techniques. Assign one of the workshop objectives to two or three participants, either verbally or allow a literate member of the group read out the written objective. Ask participants to grade, out of a possible mark of 10, the extent to which the objective was met.
4. Alternatively, go around the class asking them to state "one thing they will be doing from now on as a result of attending this workshop."
5. Collate and analyse responses.

## Notes

## Notes



A large, faint image of concentric ripples in water, centered in the upper half of the page, set against a light beige background.

# Peer-to-Peer



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